Meaningful Use Workgroup
Draft Transcript
January 6, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Meaningful Use Workgroup. This is a Federal Advisory Committee, so there will be opportunity at the end of the call for the public to make comment. A reminder, workgroup members, please identify yourselves when speaking.

Let me do a quick roll call. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Bates? Eva Powell?

Eva Powell – National Partnership for Women & Families – Director IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman? I know he's on. Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Charlene's not on. Is David on, David Tao? Latanya Sweeney? Micky Tripathi? Michael Barr will be joining late. Jim Figge? Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Murphy?

Judy Murphy – Aurora Healthcare – Vice President of Applications
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Joe Francis? Robert Anthony, CMF?

Robert Anthony – Centers for Medicare & Medicaid – Health Ins. Specialist
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off?

Christine Bechtel – National Partnership for Women & Families – VP
Judy, it's Christine Bechtel.

Judy Sparrow – Office of the National Coordinator – Executive Director
Christine. Right. Good morning. Okay. I'll turn it over to Dr. Tang.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
David Bates is on too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good morning, everyone, and Happy New Year to everyone! I think it's going to be a big year for everything HITECH and health reform and CMS. So it's going to be a big and, hopefully, a very productive and good year.

Today's call is we had our feedback from the full committee last time we met and today what we're doing is reviewing an update to the matrix based on that feedback in the form of a draft Request for Comment, so that's what you've got. I'm sorry it was late. So we're looking at this, looking at it for the appropriateness of it to stimulate questions or at least to provide our latest thinking so that we can be open to feedback and questions on it. We have a combination of some questions about any individual row, as well as some questions at the end, some overall questions. The purpose of this call is really to see whether we've gotten the questions right and we've put this in a form where we can get the best feedback on our existing work.

The timeline is that this would go out fairly soon—it could even be this week—and we would request people provide us feedback within a 30-day period. That 30 days—you might even recall last time I think we only put it out for 10 days because we were under such a short timeline. This one we're still under a fairly short timeline, because we want to ... March out so that we can produce our final recommendations in the summer of this year and that gives CMS and ONC enough time to prepare their NPRM by the end of the year and that goes toward the final rule in the middle of next year. So we're still on a timeline.

The other thing we may talk about is since we won't be getting feedback for another 30 days we may not need to have our February 3rd call. What we may want to do is talk about in the process of going through this document, this draft and after getting feedback from the public we may want to have a hearing that talks about some of the major questions or concerns that come up. One of the things we've heard about from CMS has been around the advanced directive and that is part of the question we're asking, but that may be one of the things we want to have as part of a public hearing.

Any other comments on the agenda or other issues to bring up today?

Josh Seidman – ONC
I'll just add a couple of things. I think that one of the things is that there are some additional workgroups of the Policy Committee that are hard at work on various things that will feed into this process as well, so even though we may not get a lot of direct comment in the Request for Comment on this, there may be other things. Obviously, we've talked about the Quality Measures Workgroup, the Privacy & Security Tiger Team. There's going to be a report from the PCAST Report Group and then there also are things like the IE Workgroup has been working on things, so as we do the analysis on all of the public comment from this Request for Comment, we will also be having some other workgroup reports to the Policy Committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Excellent points, Josh. Thank you very much. I'll remind people that the first time around we got about 800 comments, so that does take time to go through and summarize before presenting it back to us, so that's contributing to our timeline.

Anything else? Okay. Why don't we get started then? Hopefully you've had a chance to go over some of this. What I've done is highlighted in yellow some of the areas we may want to concentrate our comments on for today. Remember, we're not deciding things. We're looking at the key areas where we're explicitly soliciting public comment on.

On page five, the first highlighted yellow phrase talks about the drug interactions, drug-drug interactions. We had concentrated on drug-drug interactions because, one, it's clearly a source of medication related errors and it's something that we don't do a really good job right now. It's an area—and David Bates has done a lot of work on this—where with the current medication databases that are used many of the alerts that get presented back to clinicians are false positives. That means that there are things that are not necessarily going to change the quality of the care or the decisions that are made and that kind of false positive situation degrades the value of this sort of feedback from the system as part of clinical decision support. So ideally, you'd have things where you'd have it be common to ask and change your order. Again, David Bates' group also has found that if they carefully go through drug-drug interactions and have the appropriate settings and the balance between the prevalence, the importance, the clinical significance, that you can change that situation almost to the opposite situation, where you have maybe two-thirds of them accepting that alert and reacting and changing their order. That would be a favorable condition.

So we were talking about we really want to move towards that goal of having a very high, positive, predictive value, providing information that would commonly cause the clinician to change their order. That's what we're concentrating on in stage two. That's what we meant by appropriate evidence based interaction.

So we did not spend as much time talking about other drug interactions, like drug-lab or drug-diagnosis and those are also important. So the way we have it in the current matrix, we put a placeholder of working on these other drugs, drug-disease, drug-lab kinds of interactions in stage three.

I'm just pausing here to see if we've captured our current sentiment correctly in this matrix and we're asking for public comment on that.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
In the previous matrix, in stage one, we had included drug-dose and drug-age; drug age I think also because of the linkage to the potential inclusion of the quality measure around inappropriateness with the elderly. Was it a conscious decision not to include those?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In stage two you mean?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Either in stage two or in our discussion for stage three.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure. No. Actually, let me invite the group to talk. I'm not sure we caught that when we went around the first time. They seem appropriate to me.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Yes. I think we should include them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Thank you for bringing that up, Farzad, and welcome. Any objections from the group to including that in stage two? I think it's something that you have to get to the point where you're in discreet ... is a common way of saying that, so in other words, so that it's not just text, so the computer can parse it out and calculate the dose. That probably will mean some work, but that's why we have stage two—it's not in stage one, but we may get some information from the field, but that's exactly the kind of information we're soliciting.

(Overlapping voices/mobile phone interference.)

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. I think Farzad brings up a good point. The drug-age one though, Farzad, were you referring to the geriatric population? From the kids' side it would be drug-weight, so I don't know which you were referring to.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Yes. Typically, I think that pediatric dosing comes in under drug-dose and the drug-age interactions are typically for the elderly is my understanding.

Jim Figge – NY State DoH – Medical Director
I just thought we might also address pregnancy and lactation issues if that hasn't been addressed with respect to drugs.

M
That comes in under the drug diagnosis that Paul referred to earlier or could.

Jim Figge – NY State DoH – Medical Director
Yes, just so we don't explicitly forget it.

Neil Calman – Institute for Family Health – President & Cofounder
I think that we had mentioned that as a separate issue, because lactation isn't usually mentioned as a diagnosis on a problem list and neither is pregnancy usually on a chronic problem list, so that if you're looking at the functionality it is important to mention those separately I think.

M
Pregnancy is relatively easy to handle, but lactation as a whole is much more challenging.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me just put on the draft strawman on the table for comment if we can include drug-dose and drug-age, meaning elderly age in stage two and drug-diagnosis, drug-lab in stage three as a signal and also explicitly include pregnancy and lactation.

M
Time out here, we're talking about stage two or three?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, we're talking about both at the same time. So for stage two we're talking about adding drug-dose and drug-age checking. For stage three, as part of our signal for comment is adding drug-lab and drug-disease checking and as part of "condition," health condition, we would explicitly call out pregnancy and lactation.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
I think on this one we have added a bunch of stuff in. I don't expect us to do that on a whole lot of the other measures, but I think given how patient safety is rising in terms of coming into even greater focus on a variety of federal priorities it's probably not inappropriate to have at least a discussion of key patient safety related issues here.

Neil Calman – Institute for Family Health – President & Cofounder
One of the things I think that came up in our initial discussion here, and maybe we should call this out as something that we're seeking public comment on, is how to make sure that on a specialty specific basis these things are relevant. So one of the comments that was made about dosing and stuff, especially in the elderly is that when you're looking at people who practice geriatrics or psychiatry or whatever, they're using dosages and medications in the elderly that a primary care provider might not use. So all of the sudden they're getting ... for alerts and alerts and alerts and that's true in a lot of cases where specialists, people refer to specialists to use medications in situation that are potentially not ones that a primary care provider might feel comfortable doing and so that came up the last time. So I think we should call out and question, as these things are developed we need to make sure that specialists are not being harassed by messages that would be relevant to a regular, primary care provider, but not necessarily to somebody who is a specialist in the field.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I actually disagree with that. I think that the specialists benefit from getting the decision support too.

Jim Figge – NY State DoH – Medical Director
Yes. I agree with Dave. I think part of the problem is that the specialists know the drugs in their own field, but those drugs can interact with new drugs that are emerging in other areas that they may or may not be aware of, so this can be incredibly helpful even for a specialist.

Neil Calman – Institute for Family Health – President & Cofounder
I'm not suggesting that you eliminate all of the drug interaction checks. I'm just suggesting that we ask for comments about how, going back to David Bates' original question, if people start getting a lot of things that are irrelevant in their specialty they're going to start ignoring everything. I think it's important that we be able to create a context for this stuff.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is such an important area and such a common area for clinical decision support it's worth probably having a special section of our questions to tease out exactly the kind of feedback of the questions we're imposing and the kind of feedback we're interested in. So rather than just having the brief words in this cell, we may want to expand on that to include all of the comments that have been made. This is really important.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
That sounds fine. Remember that we had a whole conversation about how we're going to get drug and drug interaction running by 2013 and will ... be there in time—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
But I don't want to add too many new things, like when you do drug-dose checking how many of them do you have to do, all of them, one of them?

Neil Calman – Institute for Family Health – President & Cofounder
That's not the questions I think we should be posing to the public. I think the questions are what do people know out there about best practices in this area or that they've been doing that could potentially inform our work. That's why I'm suggesting that we just put the question out about how to make certain of these things more relevant in particular specialty areas. I just think you're absolutely right that we should be highlighting this as an area where there's lots of room for people to make intelligent comments that we could learn from.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's very helpful discussion. Let me queue David Lansky in, if he could give us a brief update on the status of the Quality Measure Workgroup. I know they just had an RFC close recently, so maybe just a brief status of your timeline and maybe you can interject a note about this particular row on drug-drug interactions. Would you expect having some kind of quality measure to help us assess where we are with this?

David Lansky – Pacific Business Group on Health – President & CEO
Actually, I might ask Josh, who may have more current information than I do. This process, as you said, the RFC has been just closed and we haven't seen any of the results from that yet. The structure of the Request for Comment is a pretty high level of abstraction, so whether or not there will be specific responses to address this topic I just don't know. Josh may have some more, current information. Our timeline is to review the responses this month and try to present at least a preliminary report at the February Policy meeting.

Josh Seidman – ONC
Yes. Basically, by next week we'll be finishing up an analysis. We'll get that to the Quality Measures Workgroup by the middle of the month and then toward the end of the month the Quality Measures Workgroup will review that, those comments and then hopefully by early February be able to come back to the Policy Committee with some input.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. So, David Lansky, would it be the expectation that the Quality Measure Workgroup look at designing an actual measure? I know that the comment, the RFC, deals with conceptual levels. Is it the intent that the workgroup would eventually get down to a measure that would help us assess the effectiveness of drug-drug interaction or drug kinds of alerts?

David Lansky – Pacific Business Group on Health – President & CEO
Well, we'll see what we get. The concept is in there for a response and whether measures are submitted—at this stage, we are expecting responses to the RFC to be specifically documented measures. So if someone brings us something and maybe David Bates knows what's likely to be coming in on that track, but whatever comes in to us that would respond specifically to that outcome measure we would obviously want to receive that.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I don't think that there are any documented measures. There's the leap frog test, which really is just a little different than the usual sort of measure, so I think this is a place where there's some work that needs to be done.

David Lansky – Pacific Business Group on Health – President & CEO

I would say, Paul, this issue of sort of the dialogue, the balance between this list we're looking at today, which goes after functional criteria and competencies, capabilities, versus the tilt toward the outcome measures and the Quality Measures Workgroup, this one is sort of in the crack between them. It may be fine to emphasize the detection competency that's indicated here and, as David said, hopefully someone will put out some research funding to develop the measures that are at the outcome edge of it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So if we find ourselves in the crack, like in the spring, then one of our groups should come up with something. If we have an ability to assess effectiveness that would be ideal and if not, we may want to just look at are you able to even detect these things as part of a roadmap towards effectiveness.

David Lansky – Pacific Business Group on Health – President & CEO
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's where we might come in for stage two, for example. Okay. Because right now in stage one it's just turned on. It seems like there should be something in between, a stepping stone between turn it on and make it very useful. Okay. This was a good discussion. Thank you for kicking that off, Farzad.

M
All right. I ... I can send that around afterwards. Farzad, you're saying that drug dosing was in our recommendations to HITPC?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
It was. It was proposed for stage two.

M
I'll find it. All right. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The next one—and it's just a question to the group, because somebody asked the question in e-mail—for the eRx we had put in stage two; that's what's highlighted; if it fits patient preference. I think what we meant was what the patients wants to decide later, where to take their prescriptions or that that pharmacy doesn't participate with eRx yet then that should not count against the provider. That's sort of what that meant.

Any difference of opinion there? We might be more explicit in what we mean there. Some of these things, guys, maybe what will happen is there are footnotes to explain what we meant in the rather concise way we put it in the cells.

Jim Figge – NY State DoH – Medical Director
One of the Q&As on the CMS Web site actually addresses the situation where the pharmacy doesn't accept eRx and in that case an intermediary will fax it and, according to CMS, that counts for the prescriber, so it should not really be an issue if we go by that CMS guidance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, the other part of a patient though is they may not know where they want to take it, so you wouldn't want to fax it—you still wouldn't know where to fax it.

Jim Figge – NY State DoH – Medical Director
That's fine, yes, but the fact that a pharmacy doesn't accept eRx doesn't hurt the prescriber.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Just an observation was that in the drafting the first stage of meaningful use, there's a real ... to be able to fine tune exactly who the right action is, but the writing it into a reg and operationalizing it and then measuring against it and auditing against—

M
All of that stuff?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Yes. Those brought up, often times, operational issues that made it very difficult to turn something like if it fits patient preference into something that could be implemented and audited.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right. That was why this question was being posed.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
And then the burden of additional data entry needed on the side of providers to then be able to withstand an audit of was this or wasn't this. So just in general, in stage one a lot of those, which seemed to be very reasonable, were taken out and addressed through other means by reducing the percentage, for example, of the threshold because it was thought to be difficult to operationalize an audit and impose a data burden on the provider. So that's just something for you to consider as these recommendations go forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you again, Farzad. With that in mind, I guess one of the options is to reduce it from 60% to 50% and 90% to 80%, as an example ....

Deven McGraw – Center for Democracy & Technology – Director
Yes. That seems to make sense to me. I think it would also be helpful to find out—and we wouldn't need to do this before the RFC went out, but—if, for example, Surescripts has any data about how often, where the physician is e-prescribing that the patient chooses not to do so. Either because they want to have some flexibility at the pharmacy or they just are more comfortable with carrying a paper prescription.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's an excellent point. That would be a very useful point, piece of data. So as a placeholder, we'd like to reduce both of those by 10%. Certainly, people who already have the functionality up and running, reducing the percent doesn't change their behavior, so we haven't dis-incented anybody. What we have done is reduce the burden for those where, perhaps in a rural area where we might have more trouble with an eRx, reduced that burden.

M
I think that makes sense.

Deven McGraw – Center for Democracy & Technology – Director
Yes, me too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So 50% and 80%? Okay. Okay. Good. Josh, maybe we could ping Surescripts for some of that data. That would be a really interesting piece of data.

The next yellow highlight is the maintain problem list and just highlighting the fact that what we had talked about, our ideal, and it was even our ideal in stage one, is to have an up-to-date problem list. That's the only way that anybody is going to benefit, either the patient or their professional health community. The challenge is how do you do that in a non-burdensome way. What's an example of being able to do that? Well, we even did this in our organization is having a sample and a peer review to see compared to the chart is this problem list up to date and accurate. That's where we'd like to be.

What we've talked about is it's really hard without a manual audit to do that. Can we, through our care coordination and exposure of problem lists to the patients, etc. in a sense inherently drive this to become more and more accurate. That's a legitimate rationale and approach. We're just checking with everybody now is that the approach we'd like to expose to the public.

David Tao – Siemens Health Services – Interoperability Champion
On this and the remaining two that follow about med and allergy lists, the whole up-to-date concept seems wide open to interpretation. I wonder if the committee could give any more guidance about what they mean. Does that mean comprehensive, up-to-date in terms of what's currently active or up-to-date in terms of everything that they ever had or those kinds of things. I realize it's not the same as stage one where they just sort of have to have one problem on a list, which presumably the one is up to date, but that doesn't mean it's got all of the problems, so I just feel like the up-to-date is going to lead to lots of speculation as to what is intended.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think, David—and David is representing Charlene Underwood today—we did mean in the conceptual and the how professional perspective and we put it in stage three knowing that it was going to be hard to do and hard to measure the perspectives you're suggesting, so it's sort of an exercise we left for ourselves later. I think you heard the rationale of what we're trying to do and an approach to making that more and more and we meant everything—comprehensive and accurate.

David Tao – Siemens Health Services – Interoperability Champion
Okay, so that by the time it becomes normative for stage three the definition will have been fleshed out more. Is that what you intend?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we'd have to do that.

David Tao – Siemens Health Services – Interoperability Champion
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are people still happy with our approach, meaning we're not changing what's stated in the final rule for stage one, we aren't changing that for our proposal for stage two, but we're hoping that through these other mechanisms it will cause the problem list and the med list and the allergy list to become more and more accurate and comprehensive.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Just to understand—is the up-to-dateness something that the group is recommending to be evaluated, audited, assessed as part of CMS' responsibilities?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

M
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It was actually probably the same thought process we went through for stage one. We couldn't figure out an automated way of assessing the up-to-dateness.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we were saying, well, it's probably okay or we hope it will be okay because there are other forces, meaning exposure to the patients and through the care coordination functions and health information exchanges that would make it in everybody's best interest and make it more and more up-to-date.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
I just wonder then what it means to have—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Somebody's typing and it's blocking out.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
I just wonder what it is signaling then to say that in stage three they will be up-to-date.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I would say as an example, from a provider organization point of view, with that signal we should start developing mechanisms. I gave one example, so we have a peer review process where you get ten charts from somebody else's and you go in that chart and say, "Is this problem list or is this health maintenance list, "up-to-date"?" That's a way that an organization, a provider organization can cause their list to be up-to-date. You can see how that serves everybody.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Yes. The only kind of other approach to quality assurance that I've heard about would be to look at other objective findings, whether it's lab findings, medication—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Oh, yes.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
—or vital signs and then ask the kind of question of of all people who had two or more blood pressures that have been elevated within a six-month period, maybe even who are on an antihypertensive medication, maybe not, how many of them have a diagnosis of hypertension on a problem list.

M
I think this whole area is going to advance a lot between now and then. We've done some work around this that shows that you can find a lot of problems that way and make suggestions to providers and that may be an easy way to get them to work on their problem lists, even people who don't use them very much.

I think yet another approach would be to look to see how recently the problem list was updated or what proportion of the problem lists were updated for a provider over a certain interval. We didn't know what those figures really should look like, but if we send the right signal, it would be relatively easy to figure that out between now and 2015.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Another example is pretty simple, the encounter diagnosis. If you have a lot of encounter diagnoses for something and it's not on the problem list and it's a chronic disease that's another clue. So this

represents a signal of, one, to do more research on that area and, two, that's where we'd really like to be by 2015.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
I'm thinking about this idea of making the problem list and the med list part of the patient's visit summary and relying at least in part on the patient to say, "Hey, you know what? This is an old problem," or, "You don't have this medication." I'm not adverse to it, but I have some concerns and one of them really is a question. That is if we take this approach it would make some sense to me if under some of the patient-family engagement criteria we ought to spur the development of the ability for the patient to electronically suggest corrections and updates to information. Rather than creating a very cumbersome process where the patient's got to call or go in or do whatever, it would seem to me that this is an opportunity to support electronic submission of there are some other elements here that you don't know about. I think that would flow nicely with the notion of downloading data. It begins to get our feet into uploading data in sort of a very intermediate way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. I'll just give another example from our practice just to show how that's done is we do have a link. So on our PHR, there is a link to say Update Your Record. What happens is then that goes to a licensed professional to take that into account and update the record—

Christine Bechtel – National Partnership for Women & Families – VP
Exactly and so I'm just wondering if we need to begin to at least ask for comment on it, but I mean I think we should include that capability so that we develop some standards and functions around it.

Deven McGraw – Center for Democracy & Technology – Director
I like that idea and it's also come up in Tiger Team discussions that we've been having on data quality and appropriate matching of patients to their data, because if a patient sees something that they know is an error that there is some sort of auto alert. It helps set the process of correction in motion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Josh, this has been a very interesting discussion and it seems like it's very worthwhile to somehow annotate this without cluttering up the matrix itself, annotate it so that we bring up these issues and solicit comments on this.

Art Davidson – Public Health Informatics at Denver Public Health – Director
In our institution the problem list is auto populated by the encountered diagnoses, so would that be considered up-to-date?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's an interesting method and it brings up the famous case of .... Probably where he got his visibility is his problem list got populated in something similar to that, in other words, the billing diagnoses started appearing. The errors that that causes was the subject of that *Boston Globe* article.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So we're saying that that is not going to be sufficient?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's certainly been our experience that that isn't.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Yes, somebody has to be minding the store.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Marty Fattig – Nemaha County Hospital – CEO
I don't disagree at all with the idea of patients being able to correct errors that they see in their record, but I think that's an issue for a different day. Back under ..., we have offer capabilities of uploading and incorporate patient generated data. I think we could include that there rather than complicate this one anymore.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. All right. Can we move on? Good discussion. The next area is the lab results. Here again we're responding to one we thought about where the labs, particularly again in the rural areas—and I think Marty helped us with that one—is when you don't have the options. When a provider doesn't have available options or certainly not complete ones where the lab's resources that they use can't return the results in a structured way, so this is an acknowledgement of that. Any other modifiers there or further explanations?

Judy Murphy – Aurora Healthcare – Vice President of Applications
The only other issue there is that that was already called out in stage one in the specification standard. It did say you only have to incorporate as structured data those things that are capable of being put in structured data, so I'm not sure if we're going to actually need the qualifier there in the statement of stage two itself.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, there were two things. One is, yes, like the x-ray results or the echo results, that was "excused," but here we're talking about when we move it to core, see ... so people could just say, "Oh, my labs don't have that. My clinical labs don't have that." When we moved it to core you all of the sudden made it everybody had to respond to that and then the concern is if even my clinical lab doesn't do that how do we excuse them?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Again, this was hotly debated in stage one as well. I think we remarked on it in maybe the NPRM or in comments on the final rule that the ability to make that determination on an individual provider-by-provider basis and to audit that and to provide those exceptions and exclusions and calculation of what's appropriate for the denominator is very difficult.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That certainly sounds reasonable. One could imagine there could be data, just like there are going to be these provider directories, that there could be lab directories and you could almost know, based on the claims data, this provider refers to that lab vendor and know whether they're in the directory that says they comply with the electronic lab interface, for example. One could imagine that could be constructed, but I don't know whether that would be helpful.

David Tao – Siemens Health Services – Interoperability Champion
I feel like there's a bit of a hole or an inconsistency between this requirement and the very first one on CPOE that says, "Orders don't have to be electronically transmitted," which wasn't flagged in yellow. But I thought maybe that's a bit unambitious especially for stage three and especially for like inpatients in settings where pretty much orders are electronically transmitted to lab systems. So there may be a consideration of varying criteria, hospital versus EP. But also, if they don't have to be transmitted, the whole thing about reconciling the results with the structured lab orders seems like it would be very hard or impossible to happen, because you've got the orders and the results aren't connected because the systems are islands. So it seems like maybe we might consider, at least for stage three, something about

we really do want orders to be electronically transmitted and those are the ones you could reconcile with the results. Because otherwise I feel like those two requirements are sort of out of synch.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think part of the problem here was some of the rural areas don't have access to broadband and we don't know when that will occur. Also, many of the smaller, rural labs just simply don't have the infrastructure to do this. By requiring it, we would basically put them out of business. So it's mostly a rural issue.

David Tao – Siemens Health Services – Interoperability Champion
Okay and we think that by 2015 that still will be the issue, because that is a few years away? But also I thought in hospitals—I may be wrong—maybe there are small, rural hospitals that don't even have lab systems, but I thought that— I mean we could still provide an out. Like if there isn't a lab system available you don't have to do this, but it's sort of like the population health says you have to transmit to an agency or immunization registry where one exists. So that could be said for the CPOE, like if you have a lab system, inpatient or outpatient, that is capable of receiving structured orders then you should send it and then if that's true then you could do this reconciliation of results with orders. But right now it says that you have to do results and structured orders, but it doesn't say structured orders that are transmitted to the lab, because you could have structured orders in CPOE and you could have results from lab, but if there's not a connection I don't see how you can do this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
David, this is very much unlike CPOE, which is influencing the ordering process, the ordering behavior of the health professional. Here we're talking about having structured results. Yes it is better and we talked about this and Charlene was there; we talked about what we're trying to do, it would be nice if we could connect it to the order, but what we are also seeing of value is just having structured results so that the computer can plot them, etc.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
I think there are others who can speak to this more personally, but it is certainly not uncommon to have unilateral lab interfaces today in the outpatient realm where the matching is done partly automated and then partly manual.

Marty Fattig – Nemaha County Hospital – CEO
One of the things that I would mention is that anyone who is working to achieve stage two has obviously met stage one objectives and if they have met stage one objectives, chances are they're going to be able to do that, even in the ... lands where I live, so hopefully this will work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So I think we have this covered, the caveat is what Farzad mentioned, which is it can be hard to know whether they can or can't. Maybe over time more and more will have to just to serve the needs, but also I supposed there could be a database that makes it easy to ascertain which labs are capable.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
I should also note that the absolute emphasis of a lot of the work we're doing, both on standards interoperability, as well as for the State Health Information Exchange Program, is around bringing up the lab capacity to participate in exchange, so the context may be changing over the next few years.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's good.

M
Farzad, will there be funding for the labs? Because it's generally not an issue that the labs don't want to do it, but it's very expensive for them to convert from old, paper processes to being able to participate

electronically with structured data and many of those small, rural hospital labs, for example, just simply can't afford it. So is there a plan that there will be funding or grant money for that?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
The answer to that is that there are lots of activities at the state level to facilitate the infrastructure for connecting hospitals for information exchange. One of the things, the low-hanging fruits there, is to get exchange of lab data out of hospitals and into EHRs. There is some funding that we just—there was an FOA from CDC around coming up with reusable tools that could use, for example, common exchange engines, interface engines or LIMS systems to be able to enable standardized messaging and electronic filtering of reportable conditions that could also bear fruit. There is also, however, I would imagine, the potential for regulatory encouragement and incentive for hospitals. I think one of the IE Workgroup recommendations had been actually to include that as a meaningful use requirement for hospitals; that they provide structured lab data on the clinical lab side to outpatient providers. So I do think that that, plus the ACO and other things, which make care coordination desirable, I think the movement will be towards the increasing liquidity of lab data from including hospitals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right. I think we can move on. The next one is on page eight for getting back into access and copies, etc. So hopefully we've gotten this right. So this is for the eligible hospital and this is discharge instructions—

Josh Seidman – ONC
Paul, I have to clarify. Did you want me to make any changes on that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I think we basically reconfirmed what we talked about in our face-to-face.

Josh Seidman – ONC
Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And so page eight, under Engage Patients and Families under the, "Provide electronic copy of discharge instructions for eligible hospitals at discharge," what I highlighted was, I think, the latest that we have in terms of what we thought—we used the term may. I suppose that's an invitation for a comment. We enumerated some of the components of discharge instructions like the patient's condition, discharge medications, activities, diet, follow-up appointments, pending tests, referrals, scheduled tests. Those are some of the things that we came up with. Any modifications to that or change in the strategy of trying to invite comment on here's a draft list of some of the required components of discharge instructions.

Christine Bechtel – National Partnership for Women & Families – VP
I guess my preferred approach would be to go back to, I think our original language was a little bit more prescriptive in saying that it should include those things and then to ask an explicit question in the list of questions later, because I think it's going to be harder to come off this one. I just don't want to end up with a situation where what they get electronically is here's your conditions and your meds and that's it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The public comment we got during our hearing was not to define the discharge instructions or at least find out what discharge instructions really are before we go and make it up out of our heads, because people are doing them, so you could argue that this process will collect it. But the question is are we required to actually come up with a formal definition in order to mention the words electronic discharge instruction or not. It became may so that we could say here's what we mean by discharge instructions. It was meant as a definitional thing rather than a prescriptive thing; to say here are the requirements to meet meaningful use. You've got some discharge instructions. This is the kind of thing we mean by that word.

Christine Bechtel – National Partnership for Women & Families – VP
George, I understand the logic, but what I'm concerned about is that in stage one there were lots of areas where we really didn't define what we meant. If we're trying to foster more structured information exchange we're going to have to do that at some point, so we need to start in stage two getting people on the on-ramp.

Then my second concern is it is supposed to be meaningful use and if we end up where discharge instructions are people take the sort of easy way out and they give you two things electronically what happens if you didn't take the piece of paper with you or you recycled it because you thought, well, I'm getting this electronically. You had a lot more detail on the written, but the electronic ones turn out to be poor. So I hear you and I agree that it's not a great idea for us to assume that we know what should be in discharge instructions, but I'd rather ask the question explicitly. Say what's reasonable to include in a definition of electronic discharge instructions that would also be meaningful for patients at the same time it's doable for providers.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think this is going to be very hard to specifically prescribe, because it's going to be very patient specific. If a patient had a particular type of surgery there are going to be very specific discharge instructions that are tied to that surgery, so it's going to be very hard to be prescriptive on this, so I tend to like the way we have it now.

Christine Bechtel – National Partnership for Women & Families – VP
Well, and I think that may be the case, but I'd rather have people do some good thinking about is there a minimum set of types of data that ought to be included that can be flexible. I just rather would ask the question and see what people come up with.

Then just while I'm talking let me suggest one other thing: In the stage two/stage three text to the left of the box I'm wondering if we can say where it says, "Patient may elect to receive a printed copy," I wonder if we can say, "Patients may elect to only receive a printed copy." Because I don't want providers to assume that this somehow gets them out of providing a printed copy and I'm worried that patients will just say, "Yes, give me that and I'm out of here, because I just have to leave this place." So if we could use that word only it might communicate that all patients should continue to receive the paper instructions, as well as being offered the electronic access.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. That seems reasonable. Let me test out what I've heard Christine's proposal would be for the numerated set. I think she's saying instead of electronic instructions may include she's proposing should include and ask the question have we got that right. Let me ask, one, Christine, did I capture what your intent was?

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I think we'd say not only did we get that right, but maybe what is the definition that would work best for providers and yet still be meaningful for patients with the specific aim of getting providers on the on-ramp to ultimately providing that in more structured data that can be exchanged electronically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Then if we included the should and the question, George and Jim, do you think that would address your concerns?

M
I'm fine at this stage.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine

Let me just comment that there is a lot of work going on in this area and that people will definitely point us to some very specific things that I think will be helpful.

M
Right. Yes. That's what we're looking for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. That's just a different way of asking the question or making sure we ask the question right. All right. At the bottom is one of our new—

Marty Fattig – Nemaha County Hospital – CEO
Could we talk a little bit about the common, primary language thing? I think this is covered in other regulations and requirements that we're all faced with and I'm not sure we have to address this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are you talking about the one right below?

Marty Fattig – Nemaha County Hospital – CEO
No, over where it says, "Electronic discharge ... for hospitals, etc.," 90% of patients in the common primary language. I think that's already addressed and I think if we're going to include common, primary language we need to give a better definition of what that really is, so I do think we need to address this.

W
There is a question about it specifically in the end of the document.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I would be interested in getting some more information from, let's say, the Office of Civil Rights about what the English as a Secondary Language requirements. I'm not phrasing them appropriately. There are some requirements on healthcare providers with respect to non-English speakers, but I would really want to understand what the scope of those are, because this in particular is talking about educational resources that are not necessarily created by the provider. So I think we need to know more about to what extent those regulations and requirements cover some of these areas where we want to make sure people are getting information they can understand before we would eliminate them.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
This is all covered in great detail in the—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can't hear you. The typing is overriding the words.

Deven McGraw – Center for Democracy & Technology – Director
Can the typist please mute?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I just said that these things are given to us in great detail by the Joint Commission and also by the Office of Civil Rights and I just didn't want to muddle this up any more by including that as a common primary language as well since that's already covered elsewhere.

Neil Calman – Institute for Family Health – President & Cofounder
I think we called this out specifically because of the issue of concern about increasing disparities as we move towards electronic ... accessible documents and stuff like that. I think it's really important that people recognize that this stuff is part of that concern and that's why it was called out separately. So if we take it out of here there should clearly be an overriding statement over everything we do that all of the

documents and anything that's provided for patient digestion has to be consistent with the Office of Civil Rights requirements for language access.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we can talk about what is and isn't applicable in our overall questions at the end, but I think I would agree with both, Neil and Deven. That calling it out here just points people where it's especially appropriate and these do seem like especially appropriate places, the places where we're talking about discharge instructions and the educational resources.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
This issue raises something. When we send this up for public comment, I mean I think 2013 column and 2015 column are very different. Maybe we need to say that in this document. The 2013 we're trying as much as possible to put in whatever we're planning on putting in. After this process, we're not going to add a lot more stuff. 2015 is a best guess of where we're heading, not a ceiling. It's a lot of signaling and we're not looking for people to spend the rest of their lives commenting on common primary languages in 2015 since we don't even know what that means.

As you just said, it's just a signal that, as Neil said, everything has to accommodate all of our patients in the long run. What it really signals is that we didn't put it in 2013 rather than that it's in 2015. We want most of our comments to be on 2013, not 2015 and we don't want to spend a lot of time discussing or evaluating comments about 2015, because we're just trying to give people a feel for why we're doing it. 2015 is a rationale for 2013 as far I'm concerned.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well said. So, Josh, I think this discussion belongs up in the preamble just, one, to tell them we can re-inform them about how we developed the stage two, which is we developed this as a stepping stone towards a stage three. But we're giving stage three placeholders just to show how we developed stage two, but we're not really expecting a whole lot of comment on stage three, at least in detail.

Josh Seidman – ONC
Got it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Very helpful framing. Okay. Going now for the inpatient summary; this is at the bottom of page eight and it's new for eligible hospitals. Here again, in the comment field we enumerate our best shot at what might be basic or essential parts of an inpatient summary. Any disturbing or concerning points there? I think we would do the same strategy; here's what we're thinking about and open it up for comments.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, there are two things that have come up. Other people have talked to me about these several rows. I'm thinking we may want to just invite comments on these two topics. I know we've talked about them quite a bit ourselves as part of the public comment process to inform our thinking, at least for 2015. One is we have the human readable form, especially here for stage two, in a structured form specified for stage three. The question is do we really have to wait basically four more years to get to an expectation of structured data being transferred. Can we accelerate that, put that into stage two? What would be the barriers and opportunities to do that?

So one suggestion is to have a standard or an expectation at the most granular level or most discreet level of data storage available to the provider is also made available to the patient in this data export, so if they are exporting it to some other application it's available in that granular form.

Then a related thought is could we invite some comments about whether it's realistic to expect hospitals or providers to push data to third party destinations at the patient's request? What are the barriers to that that we can anticipate? So if someone wants to send from a non-VA provider to the VA or from a current

provider to a third-party data repository, like HealthVault or Dossia is that data transfer something that right now we're basically assuming the patient is responsible for acquiring the data from their provider and then transferring it to the third party. Could we enable that transfer directly from the source, the EHR source?

Those are the two comments people have asked ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good questions. Let's take them one at a time. The first was a very interesting proposal, saying basically match the granularity of the structuredness of the data to what you have in the EHR, so if it's in granular form in the EHR there is no reason it shouldn't be available to the patient in that granular, structured form. Did I capture that right, David?

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What do people think?

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I agree. I think that one of the things I worry about a lot within this is that we're asking a significant amount more in stage three, but some places we have real gaps in terms of there being a lack of an on-ramp in stage two. This would help in that regard, because I think in stage three if we're asking to do patient uploaded data that is structured and other kinds of exchange of structured data, if we don't do something in stage two to begin the use of the structured data it's just not realistic to do both simultaneously in stage three. So I think that's very smart.

Deven McGraw – Center for Democracy & Technology – Director
I would agree. I think the other thing that we need to be mindful of what's going on—and this is picking up on a comment that Josh made earlier—that with respect to the recommendations and the PCAST Report and looking at coming up with a common exchange language that's at more of a data element level and moving, gravitating to that kind of a structure for data exchange, I would imagine we want to be consistent with that. So where the data is structured and recorded in accordance with a certain standard it ought to be exchanged in that way too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any other comments on that point?

David Tao – Siemens Health Services – Interoperability Champion
Yes. The comment earlier about should there be some mention of pushing it to another source, I do see that several lines down in at least the PHR for stage three EHR—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're not quite there yet. We're trying to close off the first point.

David Tao – Siemens Health Services – Interoperability Champion
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Hang on to that for just a second.

David Tao – Siemens Health Services – Interoperability Champion

Okay. I would agree with the others, that if the structure is already available and in fact there are some structured formats even in stage one that, at a minimum, they have to be human readable, but I think that the patients ought to be able to get the data in a structured form as well if they can use it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any objection to moving forward with that kind of language, essentially matching the structured granularity of—?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I mean I think it's just a decision whether we want CCD and CCR in stage two or not and if it's yes then yes, but I don't think we need to talk about the granularity of the chart. I guess I don't see those two linked. I think if we want to do CCD in stage two that's fine.

Christine Bechtel – National Partnership for Women & Families – VP
George, I guess I'm not a standards person and so take this with a grain of salt, but as I started to think about this and talk with other folks I think one of the concerns that's come up is the notion that if the provider is already using like a CCD standard internally then that's great. But any other provider who is not using it, even if they have an EHR, but they're not a meaningful user, it's going to preclude data exchange in some ways.

So one of the ideas that I started to think about as an on-ramp notion is whether or not we could ask the Standards Committee to think about it should probably be a standard or standards. But what is the right approach here that might allow a consumer to specify the format that they want the data converted into so it's almost like a save as function. So if they know, in David's example, that they're sending it to the VA and the VA says, "Give it to us in an ASPE text file or give it to us in a CCD," then you can convert it that way. Much in the way that on-line banking gives you the option to have an Excel format or a QuickBooks or whatever. So I'm wondering if we should ask for public comment on the best approach in that area rather than us suggesting a single standard or not.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well, okay. I'm fine with letting both, the public and the Standards Committee worry about which standard it is, whether it's CCD, CCR, both or whatever. Although we don't want to ask too much of our vendors, but that's the data transfer standard.

The question is what's in structured form. If you look at our list, hospital admit date, location, reason for hospitalization is a short bit of text, provider, problem list, medication list, allergies—these are all coded things—immunizations. Coded or short bits of text that fit into CCD, CCR or anything else that we would come up with. So the only thing is if we're trying to pull apart a visit note is where we would get in trouble, where we get into the discussion of whether it's structured or free text. But most of the rest of the stuff, as you look in the list in the right most column is structured data and it's just a matter of when we push for a structured form to go to the patient.

So I think maybe we just drop the concept of separating PDF from CCD and just say, "HIT Standards Committee to define the standard." Period.

Judy Murphy – Aurora Healthcare – Vice President of Applications
I would agree. I'm actually on the Standards Committee and one of the things that we are dealing with right now in stage one is the data blob or the PDF. The intention always was that at stage two that would start to be more structured in a way that you could decompose it, if you will. So that's the beauty of the CCD; that you can display it in a PDF or as a blob, but of course, with the wrapper around it and the definitions you can also decompose it, know that it's structured data and actually update your database with that information. The intention, at least in the discussions that I was in, was that that would be where we'd be going with stage two, because stage one was where we were dealing with the data blob.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So the only issue is that the word structured is ambiguous. Structured could mean that if you have it in visit note call it a visit note. That's one level of structure.

Another structure is that you want every little data element within the note structured. We don't mean that right now. We just want if it's a visit note, call it a visit note. If it's a medication, call it a medication instead of a big, long, ASPE file. So I think that's reasonable to ask for in stage two. The programmers are just going to get rid of that structure in order to create this human readable form the way we've written it. So I think maybe we just say data available in— I don't know, Judy, do you want to call it a semi-structured form or a uniform form or something like that and then say let's the HITSC define it?

Judy Murphy – Aurora Healthcare – Vice President of Applications
Right and I would guess we get rid of the use of PDF or text and just say HITSC to define.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So wait a minute. I think the proposal I heard then is literally to move stage three, which is all we've done is added CCD as an example, the structured format of this information, into stage two. I mean, as George points out, all of this stuff, when we say match it's virtually everything except for the text.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that's the proposal pretty much.

Judy Murphy – Aurora Healthcare – Vice President of Applications
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I mean I think the original proposal was saying we're waiting too long for it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't think it's that much harder to produce. I mean I think when we said PDF we were more worried about the patient than whether they had the right browser and the reader; whereas, we knew if they got a PDF any browser is going to show it. If they get a CCD then they have to make sure they have the right plug-in that turns CCD into something that's readable. So we were just trying not to push the outside world. I think the HIT vendor doesn't really care either way, as long as they know exactly what they want defined. As long as people don't misinterpret structured form to mean that you have to structure visit notes; we don't mean that.

Michael Barr – American College of Physicians – Vice President, PA&I
This is Michael Barr. I'm just letting you know I'm on the call.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Other reactions to the proposal on the floor, which is basically to eliminate the distinction or disparity between stage two and stage three, i.e., move stage three language into stage two?

Jim Figge – NY State DoH – Medical Director
I think it's a great idea. I think if we drive towards going with either CCD or CCR, as determined by the Standards Committee, then lots of applications will be built that will translate those into a PDF or Word document or whatever the patient wants, so I think this is the right way to go.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other comments?

David Lansky – Pacific Business Group on Health – President & CEO
Rather than just moving stage three up a column I would just add the words and so it would say data available in a uniformly, human readable and structured form, because they do have to be both. If you just put structured they might think it doesn't have to be human readable, so I think you do say human readable and structured.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I think what works is to do it a little bit, slightly different and move the text from stage three, but also add the human readable so that people can, without investing in other applications, the patients can receive them in PDF ... we know that that's an easy way to handle it.

W
Yes.

Judy Murphy – Aurora Healthcare – Vice President of Applications
The Standards Committee will need to define both a transmission standard and the content/vocabulary standard, if you will. We're really talking about both of those if the patient is going to be able to human read it, if you will, because they have to be able to get it and then they have to be able to open it and know what it says.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I have a question about the world uniformly as it applies to the human readable. That makes me a little nervous. It sort of implies, like a nutrition label, there is some kind of national format for the human version, which maybe that's really what we want. I'm not sure. It does seem to suppress innovation in consumer and patient communication, which is high value potentially and a differentiator, either at the vendor or the provider level if people are better at creating media for pushing this data to the patient that are not a nutrition label or whatever the Standards Committee might propose. Did we settle on the idea of a uniform, human readable format for a particular reason in a previous discussion?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. We didn't want them to get PDF or text. We wanted the Standards Committee to either say what's going to be produced or for the Standards Committee to say what's going to be produced is ASPE text.

David Lansky – Pacific Business Group on Health – President & CEO
Oh, by format you just meant the technical format, you didn't mean the actual content display?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, just the transfer format.

David Lansky – Pacific Business Group on Health – President & CEO
Oh, all right.

(Overlapping voices.)

Michael Barr – American College of Physicians – Vice President, PA&I
I think that needs to be clarified.

Deven McGraw – Center for Democracy & Technology – Director
I agree. I also think we should be careful to let the Standards Committee do what they do best, which is to look at the landscape of standards and make the selection, whether it's one or two, that will work.

W
Agreed.

David Lansky – Pacific Business Group on Health – President & CEO
I guess, Deven, I'm just wanting to clarify what we mean on a policy level. Do we mean there should be a single, national format that every patient sees when they finish a visit or a discharge for how their data is displayed to them—

(Overlapping voices.)

Deven McGraw – Center for Democracy & Technology – Director
Right. I mean I got your point, David, and I don't think that's what we were talking about at all.

David Lansky – Pacific Business Group on Health – President & CEO
Then we should make that communication clear in whatever we document here.

W
I think it's just … placement—

M
Yes.

W
And I think ... data available in a uniformly structured and a human readable and we don't repeat it or something like that. I think it's wordsmithing, but you're right, David. I'm glad you raised it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
A clarification: If we put both structured and human readable do you mean you get two things or do you mean you get one thing and you have a plug-in that reads it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're saying that you have two things.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No. I don't want to get two things. No. You said one thing and it has to be such. I mean the requirement like you did with PDF; the requirement is that the thing be able to be human readable, rather than saying pushing a button and okay I want the human readable one or I want the structured one. I mean won't that create chaos to offer two things? You're going to have a Web site dedicated to telling people which ones to pick.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I mean that happens all of the time with, let's say, an article. You get to either click the link that says HTML or you click the link that says PDF. I mean it's at that level.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
All right. Well, it wouldn't be hard to implement, because you just take the CCD and put it through an SSL kind of thing that turns it into a PDF, so it's not hard for the vendor.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. We don't want to make it hard for the patient. That's the objective of that phrase. I think we're suggesting moving the text in stage three over to stage two and adding the qualifier that they also have access to it in human readable form, MED, PDF or text. Also revising the uniformly to make sure it's clear

that we're just talking about the way you transmit it, not the structure itself. Okay. Good. Good modification.

Okay. David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Paul, then two and three, are they the same now?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Any objection to that?

David Lansky – Pacific Business Group on Health – President & CEO
The only thing is you might consider possibly, since two got a little bit higher just now, maybe adjusting the threshold, the percentage a little bit. Make three a little higher than two or whatever, 70%, 90% or whatever is—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
It is. That's what 20% and 30% are in the next, following row, at least for EP.

David Lansky – Pacific Business Group on Health – President & CEO
No, I'm still talking about the hospital. If we made columns in—

(Overlapping voices.)

David Lansky – Pacific Business Group on Health – President & CEO
Say 80%, so if they—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Yes. Yes. Sorry.

David Lansky – Pacific Business Group on Health – President & CEO
—then either they are intentionally the same or one or they're the same function, but the threshold is a little lower in two versus three. That's all I'm suggesting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, David, it's actually the threshold has nothing to do with the capability; it's the amount offered.

David Lansky – Pacific Business Group on Health – President & CEO
Correct. We sometimes keep the capability the same and raise the threshold and sometimes we do both, we change both. I'm suggesting that maybe since we just made capability of stage two up higher now by making it structured, as well as human readable and stage three is going to have the same functionality capability if you want them to be different at all you could have stage two be a lower percentage than stage three in terms of offering, not in terms of .... Do we think that 80% of having the capability in stage two is the right threshold?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think because we're talking about being able to achieve both, so I would leave them both.

David Lansky – Pacific Business Group on Health – President & CEO
All right. So then you're just basically saying stage three won't change from stage two then.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. Maybe then what we would do in stage three is maybe we want to come back to that question in a second because David's second point was whether we can make information essentially publishable to a third party if the patient wants it. That could be a stage three thing too or a stage two thing; I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So what I've heard is let's leave it that 80% be offered came from Christine.

M
Yes. For comment, let's leave it like that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Okay. All right. So David Lansky's second point was making it available to third parties. Comments for that? Actually, I might invite Deven to comment on are we ready for that? What are the implications from a privacy and security point of view as it applies to the timing in stage two?

Deven McGraw – Center for Democracy & Technology – Director
Right. So we had a little bit of discussion. I had some questions about the way that this was worded with respect to the ability of a patient to view and then download it, either through a secure portal or through a business associate. We'd also had some discussions about this at the Policy Committee meeting. I'm not 100% sure how to resolve this, but my recollection from the Policy Committee meeting was that there were at least a couple of Policy Committee members who were very concerned about making sure that patients had an option for viewing and downloading their data that would be sort of part of the HIPAA umbrella. Versus necessarily being required to use the services of an independent PHR that isn't necessarily covered by a comprehensive set of rules. So we can have a discussion about whether I've articulated the concerns appropriately or not.

This came up sort of at the end of a very long discussion, but I think the bottom-line here is that, number one, I think we need to decide whether or not we want to create an encouragement of a portal. Whether it's through an EHR or whether a provider uses an outside service to create their portal, in which case, that would definitely be a business associate. Or whether we sort of leave that a little bit open and allow consumers to have some choice about the service that they might want to share with, regardless of whether it's a business associate or not a business associate, as long as the EHR has the capability of making that connection.

So I mean the general, legal landscape here is that a personal health record that's offered by an Internet-based company, not a covered entity is generally not covered by HIPAA and not a business associate unless they are offering that service on the covered entities we have. The nature of a business associate is that they're performing a service for a covered entity and not necessarily acting as the agent on behalf of the consumer.

I hope I haven't ridiculously confused people, but I think we need to word this a little bit different so that we're not seen as requiring PHRs to be business associates in order to be eligible, but appropriately addressing the privacy and security concerns that were raised by the Policy Committee. Whether the push to having the portal as at least a default option where patients can then, if they want to share with an independent PHR like HealthVault, can do that sharing on their own is the right way to go.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me try to maybe restate what you said, at least—

Deven McGraw – Center for Democracy & Technology – Director

Feel free, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, because I think there are a couple of concepts that are going on. So let me try to define portal and incorporate a component of what you said. I think of a portal as a different view of data contained literally and residing in an EHR.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The common way of providing a portal is that the provider itself, who owns and operates the EHR, has other capabilities typically supplied by that same vendor to let the patient view the same data. In that case that I just described, clearly, that entity is a covered entity, not even just a business associate.

One step removed is the provider could ask another third party to provide, to upgrade that portal into its EHR. In that case, it would be obvious that that third party is a business associate and still covered in HIPAA. Both of those seem "safe" in the sense of we understand the privacy requirements and security requirements on that organization, the covered entity and its business associate.

The next step or another step removed is now the data is going to leave the covered entity and the HIPAA protections afforded it. The patient and it goes somewhere else and then we have a little bit of this muddy water, where if it's completely somewhere else, completely under the control of the patient you no longer are covered by HIPAA through either the covered entity or the business associate.

Should we try to tackle the "patient portal" issue first and then talk about a non-portal relationship? Have I stated the notion of a portal clearly enough? In other words, another view of the same data.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Christine Bechtel – National Partnership for Women & Families – VP
I think you have stated the definition of a portal correctly and I think there are some places in here where we said PHR, which includes a portal that I think we need to clarify, but I think you've got the definition of a portal correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Maybe it's helpful, because I think of a portal as part of a PHR, but it's not, but it can lead to this confusion. So maybe it's helpful for us to even call that out. It's very clear that a portal, in this definition, will always be covered under HIPAA.

Christine Bechtel – National Partnership for Women & Families – VP
Yes and I agree, we have to call them out and treat them separately.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So let's talk about portal now. I guess we're actually getting away from it, so maybe not go to the portal in this case yet, because it's covered further down the road.

I think David Lansky is asking about the non-portal, the distant closure, the transfer of information under the covered entity's control to a third party. That probably, by definition, doesn't have to be a business associate. Is that the question you're asking, David?

David Lansky – Pacific Business Group on Health – President & CEO

Yes. I think the base case we've agreed to is you release the data to the patient and then they can do whatever they wish with it, whether that's a sufficient place for us to stop is, I guess, the question or whether we at least want to solicit public comment on that question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're definitely treading into new territory when we do that and I'm not sure, which is why I referred it to Deven, that we've completely covered all our bases on that in that area from a privacy and security—

Christine Bechtel – National Partnership for Women & Families – VP
David, are you thinking that this criteria would be something that would allow the patient to either view the data in the record, which probably happens to be a portal, download the data from the portal or wherever? Or, like a third option, which would say publish my data to and here is a list of common PHRs, so you might pick HealthVault from there. Is that the third kind of criteria you were thinking we could consider going farther with?

David Lansky – Pacific Business Group on Health – President & CEO
Yes and that list of destinations it could be either another provider, particularly for data transfer, or it could be to a PHR repository. I guess the larger question that this is raising is what is our strategy for the longitudinal health record, multi-provider health record. We have kind of a gap in our overall policy discussion about how this is where the PCAST Report comes in too. How do we get to an accessible, longitudinal record across providers?

Christine Bechtel – National Partnership for Women & Families – VP
Right. So right now we're sort of relying the view and download would mean that we effectively rely on the patient to collect information and aggregate it for multiple providers into something that's, at least in today's technology, probably looks like a PHR. You're saying should we ask a question that says should we establish a common, longitudinal health record so that every EHR has the ability to download its content to this common record that everybody can share and use and access with the patient's permission.

David Lansky – Pacific Business Group on Health – President & CEO
No. I don't know. I'm not proposing a solution.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
I'm concerned that this is—

Deven McGraw – Center for Democracy & Technology – Director
... a different issue, Christine. I wonder if rather than— I like David's formulation of thinking about it at least for the matrix in a more open way. Which is that patients have the ability to view and download either through a portal or through a service of the patient's choosing this data, whether it's an inpatient summary, the discharge summary, the sort of various categories where it's relevant. Then we should ask specific questions of people about what do we do about it. Should all EHRs be at least required to have a portal, given privacy concerns with respect to independent EHRs? Are we creating a circumstance where EHRs are going to be required to interface with every EHR that's out there? How can we manage this to allow consumers to have choices, but without creating a situation for vendors that's problematic?

Michael Barr – American College of Physicians – Vice President, PA&I
This is an interesting functionality and certainly very important down the road, but I'm having a hard time plugging this into this meaningful use construct where somebody—if you look at my comments that I sent out earlier in terms of the EP issues in terms of providing access, making sure that patients are using it.

It's how are you going to measure meaningful use of what you're describing. It's a great functionality and probably should be part of the certification criteria, but does this belong in a meaningful use grid?

Deven McGraw – Center for Democracy & Technology – Director
I get your point, but typically, the certification requirements have been specific to meaningful use. So in some respects it's hard. We sort of need to find a way to incorporate it in meaningful use. Also, I think a number of us desire to use the financial incentives in order to support a more active provision of data to patients. So there's sort of a couple of things going on here, but at least with respect to how certification was handled in stage one and per Policy Committee requirements, certification needing to be tied specifically to what's needed to meet meaningful use, if it's not in one it's hard to get it in the other.

Michael Barr – American College of Physicians – Vice President, PA&I
Well then, I think if we're going to talk about the kind of functionality, we ought to think about how would you tie this to meaningful use. Because I'm not seeing this as something you lay upon the eligible providers to make sure patients download and save as and send as we're trying to do it that provide clinical summaries for each office visit. It's a stretch for me to kind of put it in that same rubric, which is what it sounds like we're trying to do.

Christine Bechtel – National Partnership for Women & Families – VP
What we're doing here is saying that the EHR has to have the ability for the patient to view and download when they want.

Michael Barr – American College of Physicians – Vice President, PA&I
Well that's fine. That's a functionality, but what's the meaningful use measure?

Christine Bechtel – National Partnership for Women & Families – VP
Whether or not the patient is able to view and download.

Michael Barr – American College of Physicians – Vice President, PA&I
So then it's an offering of this?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, that's it.

Michael Barr – American College of Physicians – Vice President, PA&I
Well then, that's basically saying that meaningful use is a function that should be embedded in EHRs and that practices have to offer it, which is what you're doing for the hospitals, but what we're not doing on the eligible providers for the clinical summaries. So my concern is as we appropriately express, if that's the model and functionality that needs to be there, and we think about the impact on the practice and how you're going to measure whether it's "meaningful use," because I do think we're entering some tough territory to try and impose this upon practices.

Christine Bechtel – National Partnership for Women & Families – VP
I think I'm not completely following you just because we are on the eligible hospital thing. So that's what I'm responding to, because we haven't gone to other areas yet, so I'm—

Michael Barr – American College of Physicians – Vice President, PA&I
Right, but the eligible provider one started as offering and now we're saying 20% or 30%. So I'm just anticipating how we're going to ... it out.

Christine Bechtel – National Partnership for Women & Families – VP
....

David Lansky – Pacific Business Group on Health – President & CEO

This is a tough one, because I think we have a four-year window we're talking about here through 2015. That it's a shame if we don't take this opportunity to start to put in place the expectation of a longitudinal health record and that providers will access it as they provide care and contribute to it after they provide care, but we're not ready to describe what that is and what the architecture for it is. So if we get to 2015 in the calendar and we haven't made progress toward the ability to construct a longitudinal, multi-provider record and the expectation that providers will consult it when they deliver care that would be a shame.

Michael Barr – American College of Physicians – Vice President, PA&I
I'm not objecting. Again, I said I like the functionality. I'm just saying that if there's a measure going to be attached we have to be smart about how it's going to be structured, because otherwise it's going to create the wrong kind of incentive and people will react negatively to it, even though we're all trying to go in the same direction with describing it.

David Lansky – Pacific Business Group on Health – President & CEO
... I'd go back to something we talked about early on in meaningful use, for example, when the Surescripts people raised the issue of why the medication history was rarely consulted during e-prescribing activities and it raised the discussion of what is the expectation we want to support around the ability to access the patient's history. We haven't really come back to that and I guess I don't know the right answer. For the purposes of the public comment process that we're about to launch, I'd be happy if we could just find a way to solicit some advice and comment on what does the public and the industry think is a reasonable pathway at this, where we are today, to get us down the road. Because I don't know what it is, but I'd hate for us not to address it.

Michael Barr – American College of Physicians – Vice President, PA&I
I could support that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that it's reasonable to have that question, which is how do we do a longitudinal record. I don't think that we could suggest that our solution is the independent PHR vendors, which are not business associates, not under HIPAA and have to make their money by advertising is the way that we could suggest the nation implement longitudinal records. So I think, as was said, we don't want to be in a situation where we tell the vendor they have to connect to every PHR, because it won't be feasible. Actually, right now I don't know if anyone on the call has connected to a PHR. We have. It's actually a lot of work. For each PHR it's another $200,000 investment. Today when the standards are there and HIE really works then there won't be that investment any more. So I think for 2013 I don't think we can mandate that each ET and each eligible hospital and provider has to connect to the patient's PHR of choice. But if standards and HIE advance over the next two years, maybe in 2015 something like that is possible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can I suggest that we take David Lansky's suggestion and move it into an open ended question at the end? Because we've spent so much time on this part I hate to have unintended consequences of starting to move ... language into this section. Is that fair?

David Lansky – Pacific Business Group on Health – President & CEO
Can I just comment that, as George is, I'm really nervous about this one? It just ends up being a huge amount of work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That might also be speaking too. Let's have that discussion, but as a separate question so we can start figuring out what can we do about the longitudinal care records. Is that fair?

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So I think we've done some major surgery on this one; I think for good reason. We changed the language and really moved it up to stage two, at least for the structured data.

Okay. So moving into the EP side, where we're talking about clinical summaries, it's really the same question. Now Michael Barr might have the same question, which is is there any reason to have the human readable separate from the structured text with all of this information? Most of this information is already structured.

Christine Bechtel – National Partnership for Women & Families – VP
What I like about applying the same logic that we just did previously here, which is to shift it a little more towards the structured in stage two is I've been struggling since the Policy Committee meeting where Dr. Blumenthal really challenged us to do more on data exchange. I mean this is supposed to be stage two is like the stage of data exchange, so if we don't lay the groundwork for having the data be more structured and at least allowing the patient to move it around that is at least an on-ramp toward much more robust data exchange. So I like applying what we just did here.

Michael Barr – American College of Physicians – Vice President, PA&I
I think the ACP has been very supportive of the structured data collection as early as possible, so I don't think the College would have any issues with it and I think it's a good idea, as Christine had said.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Going once. Other comments ...?

Marty Fattig – Nemaha County Hospital – CEO
If we're going to have a structured data set do we need this laundry list of things that need to be included? I'm cautious there because I don't want to include something that we can't provide or not include something that we should.

Christine Bechtel – National Partnership for Women & Families – VP
Can we ask for comment on that?

Marty Fattig – Nemaha County Hospital – CEO
That might be a good idea.

Christine Bechtel – National Partnership for Women & Families – VP
That would be important to know, if we end up that there isn't a lot of structured data in some of these areas it may mean that we need to continue that real blend of human readable, because it's really important in meaningful information.

Marty Fattig – Nemaha County Hospital – CEO
Aren't we asking for it? The right most column says, "Here are the data elements," and we're looking to see if—

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Marty Fattig – Nemaha County Hospital – CEO
So that is our question. That's, in fact, why that column is there.

Michael Barr – American College of Physicians – Vice President, PA&I
Right, but we don't want to do anything that would imply that we're limiting it to structured elements if there's no structure yet defined.

Marty Fattig – Nemaha County Hospital – CEO
Well, again, I'm worried about the ambiguity of the words structured. As Judy said, it's like semi-structured. What you have, if it's a visit note then that's what you've got and you label that as a visit note and you keep it separate from the immunization, but it doesn't mean that every little physical exam feature is a separate data element.

Michael Barr – American College of Physicians – Vice President, PA&I
Exactly.

Marty Fattig – Nemaha County Hospital – CEO
So maybe we need to clarify that. I don't know.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think so. The same clarification that applies above, but the strategy is here is what we think are included and whether it's a hospital discharge or an encounter summary and ask for comment. What we can do to see more explicit value and we're asking for public comment on this list and also the caveat about the text, like unfortunately ... visits and progress notes are not structured. We don't have standards on those. They're neither structured nor do we have standards for them right now. Okay. That's good.

The next section is the same thing and we're applying it now to access. So we've talked about summaries. We talked about discharge things, we've transferred documents, now we're talking about access and it's the same deal. Any problem with applying the same operation, moving stage three structure into stage two?

David Lansky – Pacific Business Group on Health – President & CEO
No. The only thing that's seeming difference in this list versus the list above was just longitudinal care plan gets introduced here, where I don't think ... in the download or ... either. I think it could be more clearly defined or that it's actually equal to some of the things up above then maybe it could be made consistent. It looks like otherwise the data list is the same.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. So how are we going to define or how do we ask the question what is a "longitudinal care plan"?

M
We had a long discussion about this and there's not a data structure for it yet, but we also just feel that it's pretty important to include it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So do we indicate with a footnote that this one of the things where we recognize that there isn't' a current structure for that?

M
I think that would be good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
But, Paul, I have a question. I always thought of a longitudinal care plan as something that is specific to a particular condition and a timely, electronic access or diagnosis or whatever, a timely, electronic access was, I think, supposed to be a more comprehensive view of the record itself that you can then filter by

encounter or condition, etc. That's what we sort of have in here. So it may be one of the filter criteria would be Filter by Care Plan or something. I don't know.

M
It doesn't have to be condition specific today the way that people talk about things most of the time today.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In other words, in one it's not particularly defined. In two it is not structured in the way that you might want to see it; it's a mixture and our first step is to at least let everybody on your care team, including you and your caregivers, know how this whole notion of a longitudinal care plan is.

Christine Bechtel – National Partnership for Women & Families – VP
Is a longitudinal care plan the same thing as a longitudinal care record?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Not really.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I'm lost. What are we talking about? Are we under timely access or under the longitudinal care plan?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're under timely access—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Which is a longitudinal record, nothing to do with the care plan and the data elements—

M
No, but the care plan is included in the list.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Yes. Yes. Longitudinal care plan, which we then try to define later down in the matrix?

M
Correct.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Maybe that needs some clarification—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
At least a "See Below," in which case we're going to have to come up with all of these disclaimers and acknowledgements anyway.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Yes, I think we have that yellowed anyway. Why don't we talk about that when we get to the yellow part?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So this is okay as well? We're moving up the structure timeline. All right. The next yellow is page 12 at the top—

Christine Bechtel – National Partnership for Women & Families – VP
Can I flag something on 11?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
There will be actually two things to flag. The last row offers capability to upload and incorporate patient generated data. I think the on-ramp for that in stage two that we just talked about is the ability for patients to report or submit corrections to their information in the records. We need to add that here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. Okay. Add corrections.

Michael Barr – American College of Physicians – Vice President, PA&I
I want to be in the queue here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
Then for the three blanks above it I think we ought to add a question, maybe at the end. Because I know the Policy Committee has already approved these, so it's tough to add like brand new things, but it seems to me that if we're asking co-writers to do the things in stage three of electronic self-management tools, capabilities to exchange data with PHRs and capabilities to report experience of care. I wonder if it's useful to ask the public whether there are important sort of on-ramp foundational steps for those particular pieces that should be included in stage two or not.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm lost on where you're talking about.

Christine Bechtel – National Partnership for Women & Families – VP
Right above on page 11; there are four criteria in stage three that do not have a stage two counterpart—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Christine Bechtel – National Partnership for Women & Families – VP
What I'm saying is I think it's worth asking a question of the pubic, having an order for providers to successfully get there in stage three are there pieces that we should include in stage two so those … aren't blank and we actually get there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So on page 12, the top one—

Michael Barr – American College of Physicians – Vice President, PA&I
No, Paul—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm sorry, Michael.

Michael Barr – American College of Physicians – Vice President, PA&I
Yes. I know I joined late, but I did send to the Committee my comments on a variety of other things. I'm not going to go over them now, but I would ask that at least folks maybe power saw through the e-mail if they have any issues, but on page 11 I still want to raise my concern about the metrics for the objective sets, the subjective ... for providing timely, electronic access to provide clinical summaries on—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Hang on. Page 11 you're saying?

Michael Barr – American College of Physicians – Vice President, PA&I
It's at the bottom of page 10 and spills over to page 11. I sent some extensive comments about that, both in the memo and then on the comments on this particular draft yesterday. I still think that it's not a reasonable expectation on part of the eligible providers to have a threshold of making sure their patients use or access the summaries. So I think that's unreasonable. I'd raise that up and I'll pause for a second. I have one more on page 11.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I concur with Michael Barr. I think that's unreasonable. I think that's something that physicians have not control over and therefore can't be held accountable for.

Christine Bechtel – National Partnership for Women & Families – VP
I feel like we had this discussion, both in the subgroup, but also in the Policy Committee. The full committee approved these, so I'm sort of struggling with what we would do here.

Michael Barr – American College of Physicians – Vice President, PA&I
Fair enough. I'll just reflect it back in the comments and I suspect they'll have a lot of comments on that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Michael Barr – American College of Physicians – Vice President, PA&I
The next one then is patient preferences. It's one of the new ones on page 11 for communication medium. It's really not specified to any extent. As I said on my comments in the document, to what level of preference, by type of information, by time of day, day of week, language; so I don't know where that specification takes place, but it clearly is not specified here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think what we intended was phone or on-line.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, but what information, what communication medium? Do I want labs by phone, by mail, by on-line? Do I want appointments that way? Call me on the weekends, but not during the week? I mean this is a pretty broad preference setting, which again, I'm supportive of, but this leaves it wide open for people to interpret many different ways.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I agree and maybe we can add a question about it, but I think our intent was trying to narrow down do you prefer to be communicated with by e-mail or secure messaging versus get reminders on paper, postcards, through regular mail versus telephone. But there should be a fairly short and fixed list of preferences and we could ask the Standards Committee for help I guess, but I agree that we need to explain what our intent was on this and then ask for people for suggestions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
As a practical matter, I think what we're trying to distinguish between—and this is what we do here—is the old way is however we did it. If you've got ... and postcards or you've got a phone call, whatever it is. That's the existing way. The new way allows you to take advantage of the on-line and we found that to be useful and we do ask, for example. But that's what the intent is behind—

Michael Barr – American College of Physicians – Vice President, PA&I
I'm not objecting to the intent. I'm just saying that this is too wide open as written. I know I said I wouldn't go backwards, but in the same thing of trying to clarify things, before I got on the phone call did you address the questions I had about on page seven, about the 30% of visits have at least one electronic EP

node or patient days have at least one electronic EP node? Because I have a feeling that's also very confusing. If you didn't, we can do it off-line, but I wanted to see if it was addressed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We did not do that and I think it's part of what we discussed in our face-to-face, right?

Michael Barr – American College of Physicians – Vice President, PA&I
All right. Well, again, I apologize. I was not there, but reading it, having not been there, I don't understand what those things mean and that's what I said in my comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So we can try to do a better job with that. Okay, page 12. There was a question called out; I think it's an e-mail; about kernel providers. This is the HIE. So the new thought we had in our face-to-face was you want to move them along and you can't just say we want it not to be one. I think at one point we had five or something ... but it has to be some number, maybe greater than one and we picked three. Obviously, some people would say, "Well, gosh, do we really need three?" I'm just calling, opening up that question there for further discussion ....

Michael Barr – American College of Physicians – Vice President, PA&I
Is there a definition that I missed about what a primary referral network is?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, you missed it. Think of it as your clinical trading partners. I mean if you always admit to this hospital that is one of your trading partners.

Michael Barr – American College of Physicians – Vice President, PA&I
Right. I can infer what it means, but—

Christine Bechtel – National Partnership for Women & Families – VP
It's self-defined, so they would say this is my network of 35 and I've got to connect with 3 of them or 10% of them or whatever.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, if I'm in a multi-specialty practice that wouldn't count if I refer to the cardiologist across the hall?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It would not.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, that has to be explicit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. External is the—

M
Well that's why it says external.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
I think that people will struggle to understand the text as we've written it, so my thinking when I looked at this I was thinking back to, again, what Dr. Blumenthal said and his reaction was we didn't go far enough here and that he's very interested in seeing and encouraging us to go farther. I think this is really worth a

specific question in the end where we say, “Here was our thinking.” But really, the question that we’re asking is how to foster more information exchange in the current environment, setting some stretch goals, knowing that the issue is supposed to be about information exchange before we get to clinical outcomes in stage three. How do we do it? And invite some innovation and thinking from the field.

M
I just think that adding a little bit of text, explaining what we meant there will be helpful, because if Michael didn’t get it—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, I mean when you have primary versus secondary and tertiary; and again, knowing the system and the conversation, I can, but even external could be interpreted differently. I have a primary care practice within a multi-specialty practice. Again, it might be a different site, so is that external? But it’s in my practice, so I don’t think it’s clear enough.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we’ll define it and one way we could define it is another EHR. So clearly, that would help you understand that when you’re in a multi-specialty group practice, you’re all using the same EHR that doesn’t count. I believe there is actually text on that in the final rule. We can certainly explain what we meant by external, connecting to another EHR, and we can define the concept we meant by the referral network and maybe use other synonyms like trading partner, although that may not be ... other ways of helping people understand it; we’re trying to look for the connections.

Remember that we have this ... clause in there, this ... connector, which is one way to do it is to sign up with a health information exchange network or organization and then you’re getting multiple people being able to access and receive information. Another way is because we acknowledge that currently there’s NHIN Direct and other peer-to-peer methods of exchanging information are there, that’s why we came up with the greater than one and we picked the number three. So again, all of this stuff we can explain in text and it would be definitely worth doing.

Michael Barr – American College of Physicians – Vice President, PA&I
Okay. So in stage three when you say at least 30% of external providers, now you have to figure out what that actual denominator is—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Michael Barr – American College of Physicians – Vice President, PA&I
Which introduces a whole other set of complications for a practice or physician. So what is my actual external network? How do I define the denominator to get the 30%? I think that’s an unreasonable activity to request of them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You might have missed the discussion, Michael, where we’re going to put a preamble up front telling people we’re disclosing our stage three for a couple of reasons. One is our strategy is defined in stage three and then make stage two a stepping stone, but we’re not explicitly asking for detailed comments on what we have listed as ... for stage three. So a lot of this stuff is an exercise for the Workgroup and the readers later on and it’s still the kinds of questions that we’re not addressing right now.

Michael Barr – American College of Physicians – Vice President, PA&I
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So .... So where we're headed, we … number three because it's greater than one and we're headed towards you've got to find ways to connect with your clinical trading partners, either join an HIE network or find enough critical .... Actually 30% came as one of the experiences in ... once you have 30% … of your patients under managed care you act like the rest of them are.

Michael Barr – American College of Physicians – Vice President, PA&I
I'll just say this is going to raise more questions that you probably want, even with your caveat that you're not seeking input, but go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

M
Does this apply to both eligible providers and eligible hospitals?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. That was the intent.

M
That probably should be noted.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Any mods to the three? It's very helpful for us to be more precise in the definitions. We'll probably do that through a footnotes kind of thing. Any further … on the number three?

M
I'm getting enough static now that I'm having trouble hearing. I'm wondering if somebody could mute.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, thank you. The next one at the bottom of page 12 is a new objective under the summary of care records and I think this is what George was referring to. Here's where we're opening up for comment on what is a longitudinal care plan. We started the discussion; and you recall we had in our care coordination panel the whole notion of gosh it would be nice to even know who is on your care team and so on and so forth. So here's where we started a list and haven't finished it. One of the things we keep wanting to look up is this transitional care. There was some kind of document that was referred to in the testimony that maybe provides another starting place.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, a quick question, list of care team members: internal, external, combination? What was the intent? ... above it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
… all. You really want to know who all are providing advice, input into your care plan and who could need coordination, so it's all.

Michael Barr – American College of Physicians – Vice President, PA&I
It's both, internal and external and involves non-clinicians as well, because you have nurses, dieticians, nutritionists, case workers—

M
Exactly.

Michael Barr – American College of Physicians – Vice President, PA&I
You want the broadest list possible, so that should be also, again, either a footnote or somewhere, because people need to understand what the intent is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
It's the list of people with longitudinal involvement. I mean it's just one-time things we don't care about that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Michael Barr – American College of Physicians – Vice President, PA&I
I agree. I was just stating maybe it's obvious to you, but it wasn't obvious to me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we'll both footnote what our intent was, but also, explicitly ask for public comment on what might be a reasonable element to include. Are people okay with that strategy?

W
Yes.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's right. I know. It's hard. Okay. We have one hour to get through our additional specific questions. Let's just go through and then we added one or two at the end.

First is the whole electronic progress notes. Actually, this may be a question that you raised, Michael. So when we say progress notes, something that we had lobbied for and didn't win in the stage one, but still, at least this workgroup believes, still has value in being part of this shared record. We were basically talking about notes that are written by a licensed professional that become part of the permanent medical record. To avoid calling is this one important or that one, that's how we came up with the number one for each billable event, whether it's an inpatient stay or an encounter, an outpatient encounter. So that's where we left it, at least in my recollection. So we're opening it up for ... other, better definitions and is that clear.

Michael Barr – American College of Physicians – Vice President, PA&I
I'll just go. The page seven ones, the reason why I raised that question is I'll just read it back. It says, "Thirty percent of visits have at least one electronic EP note," so if I do 100 visits this suggests that 30% of those visits should have at least one electronic note. It didn't make sense. I was wondering if that really meant active patients have at least one electronic note, a percentage of such.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. I mean our intent is that every billable encounter should have a note about what happened.

Michael Barr – American College of Physicians – Vice President, PA&I
But when it reads, Paul, it says, "Thirty percent of visits have at least one electronic EP note." I didn't understand what that meant.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

It just meant that, yes, if you have 100 visits in that period from, say, 10 different patients, each has 10 visits, that's 100 visits. There are 30 notes. Maybe that's wrong, but that's the intent.

Michael Barr – American College of Physicians – Vice President, PA&I
Okay. I think of—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's obviously downgrade from I don't know how you actually can bill without a note, but maybe that's a—

Michael Barr – American College of Physicians – Vice President, PA&I
Well, but still, it says, "Thirty percent of visits have at least one," which would mean 30% of visits are documented electronically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Michael Barr – American College of Physicians – Vice President, PA&I
That's what you want, but what it says is at least one seems to refer to a patient. It's just worded very awkwardly. The same thing with the patient days on the next one for the EHes, I mean it says, "Thirty percent of EH patient days have at least one electronic note by ...." So the hospital is at 210 patient days this week, a small hospital based on 30 patients staying all 7 days. How many notes have to be electronic?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Sixty-three.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, that's why I'm—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Michael, if you have a suggested wording, now that you know the intent, it's that for each billable event, so that's a hospital day or an outpatient encounter, ideally we'd like to have 100% have a note that shows what you did. As an intro, we came up with the 30%.

Michael Barr – American College of Physicians – Vice President, PA&I
I would just leave it. I mean at least 30% of visits have an electronic note or say 30% of patients have at least one electronic note—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, it's per day.

Michael Barr – American College of Physicians – Vice President, PA&I
I'm back on the EP.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay.

Michael Barr – American College of Physicians – Vice President, PA&I
So 30% of patients have at least one electronic note or 3% of all visits within a specified time period are documented electronically.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think the latter is what we need.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The latter is what we were asking for.

Michael Barr – American College of Physicians – Vice President, PA&I
Right. I mean, again, I'm reading it, not having heard the conversation, which it may be a benefit or may be a detriment, in some cases probably both. So I would just say that needs to be clarified. Then likewise, on the EH, 30% of patient days have at least one electronic note. Well, okay, if I'm a patient multiple doctors are coming to see me if I have a consultant so the denominator is the total number of notes generated on that particular patient day and we're going to say 30% of those have to be documented electronically?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, 30% of the days have at least one note.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, for each ...— So, Michael, if it's clear to you—is it clearer if I say 30% of billable encounters have a note?

Michael Barr – American College of Physicians – Vice President, PA&I
Yes, are documented electronically or have an electronic note. Yes. That makes a lot more sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. We can do that. That was our—

Michael Barr – American College of Physicians – Vice President, PA&I
You could do that for both, EP and EH.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's fine.

Michael Barr – American College of Physicians – Vice President, PA&I
Okay. I'm sorry.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't think we came up with a phrase for EH yet. I mean the intent was if a patient's in for ten days that the opportunity is a day that the patient's in the hospital and they need to have at least one note on that day. If they have 14 consultants, the rule is just one of them is what they're measuring.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, actually, George, that's why billable event is perhaps clearer, so if you have—

M
No, I don't think hospitals can count billable encounters by doctors, because you don't know who is visiting, what consultant is visiting. That's why we made it a patient day.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes. No. You can't do it that way. Patient days makes sense.

Michael Barr – American College of Physicians – Vice President, PA&I
So 30% of the notes generated in any particular patient day are documented electronically?

M
No.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No.

Michael Barr – American College of Physicians – Vice President, PA&I
See?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, someone can correct me: If you have two consultants on one day, each of them writes a note and each of them can bill. Is that correct?

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So that's what I'm saying. For each billable event—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
You'll never get that denominator is the problem. What we want to say is that 30% of patient days have at least one note. I think that's actually what we said. So if you take a patient day, you take a patient, they're in the hospital on a day. You say yes/no, do they have at least one note? Then you count across all days, across all patients and you see 30% of them have a note.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
To me that doesn't sound like it fulfills our intent. For every billable event a health professional has assessed the patient and made some decisions, made some observations and they've billed for it. We'd like to have some record of what happens.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, I agree with the intent, but you can't measure that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Why can't you? You have the—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Because the hospital doesn't know when the consultant was first called into the case, so they called in the case on Monday when they got the call or on Tuesday when they visit the patient or on Wednesday when they first left a note. How do they know that consultant should have written a note on Monday and, therefore, goes to the denominator and not on Tuesday or Wednesday?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So the problem you're pointing out is in this case the hospital is the meaningful user and so it doesn't know when the provider has written a note. Okay. I get that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So you're just looking in your record and saying, "Okay. I have a patient day. I have at least one note. That's the best I can count."

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I see.

Michael Barr – American College of Physicians – Vice President, PA&I
All right. Now that I've heard the conversation, I understand it, so—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

But we should try to rephrase it. The other one I liked your phrasing, but this one I'm—

Michael Barr – American College of Physicians – Vice President, PA&I
Yes, I agree. I understand the difference and the challenge in the denominator, so but now reading it after hearing the conversation I understand what the intent was, which I couldn't really gather before, although I got the math right. It would have been 63, just as you said.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we can update that. Unfortunately, that's just a vagary of what we can capture so that in the hospital it doesn't fulfill our intent very well.

Michael Barr – American College of Physicians – Vice President, PA&I
But back to your question, Paul, about under C1 on page 14, "How can electronic progress notes be defined or have an adequate specificity?" At least for the EP I think a billable event might actually be something to throw out there, at least for comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Michael Barr – American College of Physicians – Vice President, PA&I
I don't know if that's a hospital bill ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In fact, I think we ought to use that in our matrix and it would probably be clear, at least for .... Actually, do folks even think we need this as an overall question if we just put down what we just said in the matrix? So for EPs it's a billable event, so 30% of billable events have an electronic progress note. For hospitals we clearly state 30% of inpatient days have an electronic note from a licensed professional, from a billing professional. Is that fair? We could have specific comments on that. I'm not sure we need to take up one of our overall questions. Any disagreement with that? I'll put it that way.

M
No. Sounds good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Number two we already covered. I think we are dealing with the definition of common primary languages. The question I think it was Marty that raised is isn't this already defined. Is that a question that we already can find the answer to or do we need to ask the public?

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I don't know if anybody saw the comments I submitted or not, but I made a couple of references in my comments yesterday on page eight about the Office of Civil Rights, the Joint Commission and the 5% Safe Harbor threshold. It says, "Written translations of idle documents for each limited English proficient language group that constitutes 5% or 1,000 persons, whichever is less of a population served."

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And that was from what, Michael?

Michael Barr – American College of Physicians – Vice President, PA&I
That was from the Office of Civil Rights that I found on the Joint Commission site and Justice.gov. The reference is in my comment number ten on page eight.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Are people satisfied with that definition? Christine? Deven?

Deven McGraw – Center for Democracy & Technology – Director
Yes. I mean I think so. Here is the one thing that keeps me from sort of jumping in and saying, "Oh, this is all covered by existing law. We don't really have to say anything about it at all," is that one of the areas where we call this out is with respect to making materials that are not created by the eligible provider or the hospital available to people. I'm not sure that the requirements with respect to communicating to patients extend to external sources of information that we would hope would be available in different languages.

Now, having said that, it's not really in the provider's control to get them in primary languages either, so I'm a little torn about what to do here and I recall that the reason why we address the question of primary language is because we specifically use that as a term without necessarily plugging in a definition. I mean I think one way to sort of finesse this at this stage is to reference specific legal definitions and prompt whether they're sufficient.

Neil Calman – Institute for Family Health – President & Cofounder
I do think it is within the provider's control. I mean if you're using a commercial source of discharge instructions and your community is 60% Chinese and the source that you're contracting with doesn't have discharge instructions in Chinese that is within your control.

Deven McGraw – Center for Democracy & Technology – Director
Right, but discharge instructions, that is more of my—the point that I was trying to make rather than the control point is the issue of what scope of whether it's communications or materials in terms of patient interaction are covered by those Civil Rights rules and Joint Commission requirements and what are not. Clearly, discharge instructions would be, but external sources of patient education materials, I'm not sure they are.

Neil Calman – Institute for Family Health – President & Cofounder
Right, but that's where in discharge instructions those are sometimes bringing contracted sources of material that are ... by third parties.

Deven McGraw – Center for Democracy & Technology – Director
Right, but that's where I think the law would apply.

Michael Barr – American College of Physicians – Vice President, PA&I
Yes. I know at least in the Joint Commission I was running a community health center—and you can comment, Neil—we interpreted as being any communication with patients had to meet that standard.

Neil Calman – Institute for Family Health – President & Cofounder
Exactly, so I think we're just trying to clarify that really to make it clear to people that they need to pay attention to that part now, because we don't want people just being satisfied that they're doing stuff in English when they're dealing with multi-lingual populations.

Michael Barr – American College of Physicians – Vice President, PA&I
I should go a little further. I know you passed it already, Paul, I apologize, but on page eight if I had a chance to come in earlier I was going to lobby for moving this requirement into stage two. This is a real source of health disparities and poor outcomes and trying to move the requirements in terms of providing information in the primary languages of the patients being served seemed to be almost more important than how many patients are offered the information and an electronic discharge. So if there is going to be a tradeoff I was going to lobby for trading off a percentage of patients offered the stuff for actually offering it in the languages of patients that they need.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
... concerned about what the market has right now.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, but this requirement is not a new requirement in terms of serving the patients and the languages that they speak, so I'll just leave it at that. I'll just throw it out for thought.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What I've heard so far was a discussion ... the last one is, one, when we use the word, the phrase common primary languages we can put a footnote to the drug commission or OCR requirement, definition that helps that immensely.

Two—I forgot number two—oh, that we leave in the reference to common priority languages in the two spots that. Because we wanted to point this out even though it may be a Joint Commission requirement, we wanted to point them out in the context of HIT and its information for patients that here's where we explicitly want to have this applied.

Three, I don't know what to do about in our discussion we had discussed that point and we didn't feel like we could move it into stage two with the current market.

So can we now move? This actually no longer is a question because we've sort of answered some of the questions and we'll make it clear in our matrix. Is that what people are understanding?

Deven McGraw – Center for Democracy & Technology – Director
Yes, I'm fine. I think it would be helpful long-term for us to have a discussion with the Office of Civil Rights just so we can all get comfortable, those of us who don't sort of live under the regulations and want to have a more clear understanding of what they are, that would be helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. That might be one—we are teeing up some questions for possible either add-on hearing, not a full day or a hearing with additional questions to be explored. We have the AD one, the advanced directive. This could be another one. What other questions ... come back from our public comment period. Okay.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Just one quick question about the question two here. That's what we're referring to right now on page 14, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I don't know why we had that last piece in parentheses.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Art Davidson – Public Health Informatics at Denver Public Health – Director
This is confusing. I think we just leave this thing, this question about primary languages and whether there are regional variation allowances. I don't know why we've added that piece in parentheses.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. It's duplicative with the fact that we've discussed this in that cell. So actually, Michael, do you know whether the question of regional variation, is the 5% applied to your testament area or—

Michael Barr – American College of Physicians – Vice President, PA&I
Correct. It's the service, based on 5% or 1,000 persons, whichever is less as the threshold above which. I mean if you have above that amount, 5% or more, 1,000 or more, then the requirement is you should

provide—actually, it's not a requirement. Deven, please correct me if I'm wrong, but it's a Safe Harbor, so in other words, if you're providing services at that level then the OCR would regard that as meeting the intent.

Deven McGraw – Center for Democracy & Technology – Director
Right. I think that's right, Michael.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So we've taken this out as a special question and we're really saying we're addressing it by complying with the OCR definitions in our two cells and matrix. Okay. That takes care of Art's concern too.

So number three: It's are we accommodating accessibility for people with disabilities in our interoperability objective. That's just an open question.

Number four: How do we deal with barriers to ... access in general? It can be the literacy issue. It can be limited Internet access. It can be disability. I wonder if these two questions can be combined. Can we combine the two? Josh, I think these came from you.

Josh Seidman – ONC
Yes. I mean it's just we can try to combine them. I mean they're certainly related.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Josh Seidman – ONC
I'm just trying to make sure that each of the sets of issues are addressed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Okay. So that is an open question we're soliciting feedback on.

Question five is a big one and we've had all kinds of discussion on that and I don't know that we have the answers to all of those questions, but we're soliciting public health.

W
On five, Paul, I just was thinking it might be helpful to add some examples of what we mean.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. And including what we brought in this discussion, which is the correction, so not only uploading of data, whether it's answering questionnaires or attaching to your glucometer, but what about other things that patients generate? How do we incorporate that?

Eva Powell – National Partnership for Women & Families – Director IT
I am thinking that this may need to be a separate question, but slightly related to this one. It's also related to Michael's concerns about the feasibility of the use of PHRs and having that outcome measured and these criteria, which I would support having the outcome measure in there. But I think—and this goes back to some of the testimony and certainly some of the discussion of the workgroup—is that there is clear evidence that providers, who take the time to have these kinds of discussions with their patients and that's why we included the outcome measure in there. I think it might strengthen our ability to keep that criteria in if we specifically ask for feedback on what provider experiences have been with the use of PHRs and their impact, their ability to impact the actual use of those.

Michael Barr – American College of Physicians – Vice President, PA&I

Yes, I mean ACP and I obviously support the patient report experiences into EHRs and that's actually where we think the value will ultimately come in sort of a shared space where then it becomes useful to the practice and obviously helpful to patients and families. That's where we think the thrust should be, not in setting an artificial percentage of how many patients actually have to use it, because we don't want to blow through that by creating something of value. What you're describing is exactly how you make the case that this is something you should be using, so it's not an anti-PHR; it's sort of making it real and emphasizing the value that should be created and not the artificial number that people have to hit.

Eva Powell – National Partnership for Women & Families – Director IT
Right. Well, that's where I would agree with you. Always my worry is that ultimately, we're teaching to the test and when ... on the ground, when people are trying to implement this they're going to be checking off boxes and that's, I think, relative to your point about this becoming an artificial threshold. In the same right, we need to have a threshold and we need to have something to hold providers accountable for having those conversations and actually encouraging the use of PHRs; otherwise they won't because it's an additional step and something that they're not required to do now and most providers aren't doing now. So I don't know the way around that, but the low thresholds—I don't know, maybe that gets what we're after, but I don't know. We'll see.

David Lansky – Pacific Business Group on Health – President & CEO
Could I suggest saying or wording this to say patient reported data and/or PHR data? Because PHRs can be more than patient reported data and patient reported data is not necessarily a PHR, so I think something that would cover both PHRs, as well as all other patient reported data would be good to ask about.

Eva Powell – National Partnership for Women & Families – Director IT
I agree, because it can include functional status, symptoms, etc.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the suggestion is what?

David Lansky – Pacific Business Group on Health – President & CEO
Just add the word, after it says, "Patient reported data," or put patient reported and/or PHR data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Funny. I think of it as the opposite, because if we tether it to PHRs—well, I think this is a broad question.

David Lansky – Pacific Business Group on Health – President & CEO
My point, I mean maybe it's too subtle, but PHRs can contain data other than patient reported. They can have data acquired from labs, acquired from PBMs. They do today, so that is from a PHR, but it's not necessarily a patient didn't just generate it. That was my point. So I'm trying to be a little broader and say patient reported data and PHR data basically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, instead of introducing a new concept, PHRs and then the risk is tethering it to what people think of ..., maybe we do an open paren, e.g., either patient entered or acquired from home monitoring devices, etc. just to give that, show that we've got that breadth, that ... the intent?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, the intent is to show the breadth of data that's not just from providers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Eva Powell – National Partnership for Women & Families – Director IT

Yes. I mean we had a hearing where some witnesses testified to this, so I think we should gather that as examples and leave it more open ended.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Eva Powell – National Partnership for Women & Families – Director IT
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So number six, future stages; so here is a big question and I don't know whether Farzad is still on. It is the notion of is there a waiver question. If you're already high performing do you get a bye on some of these requirements, either all or parts of the requirement? I do remember Neil talking about there is performance in certain measured areas and we use those measures, actually, as exemplars and thinking that, if you had the infrastructure to improve anything you choose to, anything you decide to work on, that's what we're after. If you score well on physics and math, but not necessarily social studies, is that good enough? That's sort of the argument, so I guess—

Christine Bechtel – National Partnership for Women & Families – VP
I just was thinking about Neil has done a good job of articulating some concerns about the fact that you could achieve high rates of performance without really using your EHR in a meaningful way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
So I actually wondered—but I also know that this is a question that Dr. Blumenthal and others are interested in—so I wondered if we could clarify that there is an assumption that under this contract for future stages it assumes that you have successfully been a meaningful user in stage one and stage two. So that gives us some assurance they're using their technology in a provision of care and then if they're successful meaning users in stage two, one and two or maybe three and two; I don't know; then in stage or three or beyond we would invite comment on this particular approach.

Neil Calman – Institute for Family Health – President & Cofounder
Since everybody's been using my name in vain, I guess that the thing here from my perspective, I think the idea of an alternative way of documenting meaningful use is what we should be after, not an alternative way of getting meaningful use dollars. So for example, in some cases where people are going to call out very specific measures and other things, I think that's where you might be able to say can you use other means. So for example, NCQA in medical home stuff there are certain pieces that are specifically related to or require electronic health records. So you would want to make sure that people are, if you're going to use the NCQA certification as an example you'd want to make sure that it includes those portions that include the use of electronic health records.

So I guess what I would suggest here is that what we could say is not really for meaningful use; that there are alternative ways of measuring or documenting the meaningful use of the system, but not necessarily alternative ways of getting to the outcomes. That's what I had commented on previously. I don't think we should allow alternative ways of improving diabetes care, because that's not about meaningful use, but what we might want to do is allow alternative ways of documenting that the use of these systems achieve those goals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Your phrase was interesting, Neil. You said an alternative way of accessing meaningful use dollars. That's very clear, but your suggestion, wouldn't that open CMS to now all of the sudden everybody is writing their own meaningful use rules and then they would have to go ... those?

Neil Calman – Institute for Family Health – President & Cofounder
Well, I think that's what you're asking. I mean my first goal would be to remove six completely because I think we're opening up a can of worms that we don't need to open up. But if Dr. Blumenthal feels that there needs to be some sort of alternative something in there, the alternative ought to be an alternative way of showing that you're meaningfully using electronic health records, not an alternative way of achieving the outcomes that we're going to call out in our outcome measures.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
I guess that's as clear as I can say it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, that's good.

Michael Barr – American College of Physicians – Vice President, PA&I
I mean I hear what Neil is saying. I think what I was thinking when I read this was the idea that everything we're working on are sort of proxies for assuming that if you do these things you're going to get really excellent outcomes over time and we don't know that for a fact yet. So I read this to mean that if an advanced practice or institution is able to demonstrate by using technology that they are doing these exact outcomes, validated, nationally endorsed measures of outcomes then why bother with having them do, I mean this is the hypothesis, why bothering with having them show that they're doing all of the interim steps.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, they can do that, but they shouldn't get paid for doing it.

Michael Barr – American College of Physicians – Vice President, PA&I
Well, no. The question is is measuring outcomes at some point, electronically reported outcomes through certified systems, going to eventually be the goal or are the interim steps continuing to measure those. That's what I'm meaning is this question of asking. It may not be, but that's how I interpret it.

Neil Calman – Institute for Family Health – President & Cofounder
I think that what happens in 2017 is you really want to be at outcomes and you don't maybe need the intermediate steps. Without the intermediate steps now we won't get the vendors to implement the functions ...

Michael Barr – American College of Physicians – Vice President, PA&I
Oh, absolutely.

Neil Calman – Institute for Family Health – President & Cofounder
So I guess that by raising it now we may be— Well, I guess I don't need to discuss whether we should raise it now, but one thing we have to look out for is that we create, as Neil said, a lot of expectations that there is a way to do this without actually doing an electronic health record.

Michael Barr – American College of Physicians – Vice President, PA&I
I agree with you. I don't think we're any point near where the interim steps need to be removed. I'm just saying I thought that for a well advanced program ... demonstrated meaningful use, as somebody else had said, that now can we just rely upon their external, reported, electronically generated through certified systems outcome data as validation that they're meaningful users of the technology we know they have.

Neil Calman – Institute for Family Health – President & Cofounder

The only danger there is if it's a subset, if it's a small number of indicators then you can gain the system by just doing those things, but not really having a high quality organization; whereas, if you actually had CCOE running you could be doing this on many diseases, not just the three where we have quality indicators. That's the danger, even in 2017.

M
I think the danger here is we're introducing a level of ... ambiguity that we're struggling hard not to have. All of the sudden we're saying at the end of this document where we're really microscopically picking apart qualifications and things that people need to do saying, "So, if you don't really think we should be doing this, tell us what other ways you might think we could be looking at this stuff." To me, I think it's just we're going to get a lot of gobbledygook that's not going to be worthwhile. I mean my primary interest would be to eliminate this question, but if we have to keep it in we'll keep it in, but I don't think it's going to get us very far.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think we're not going to solve this problem this time around either and it is a request from ONC, so I think it's something we should—

M
Okay. We'll just leave it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Number seven is allowing group— I don't actually think this is our decision.

M
I mean I don't think anybody would think this is a bad idea. I thought it was taken out of our hands.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it is out of our hands. In fact, it's out of everybody's hands. It's the law.

M
It's in the legislation, isn't it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's the law. It's the law. I'm not sure where this came from.

M
No, there is actually nothing that prevents the program from allowing this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Really?

Deven McGraw – Center for Democracy & Technology – Director
Why did we do this the first time?

W
It's a group reporting option, but it's different from a group payment option. Is that right? Which is what the law would prevent. I don't know.

Neil Calman – Institute for Family Health – President & Cofounder
I thought it was by provider ID.

M

Yes, but the question is how the data is reported. The reason why, basically, there were a number of comments in the hearings that we had around care coordination and patient-family engagement, around team based care and trying to encourage that. So the Policy Committee had conversations about the fact that group reporting would help to facilitate that. That's sort of what this question was trying to represent, those discussions of the Policy Committee and from the public hearing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But we didn't know whether that could get— So each provider under a group ID, under a group report would get the money if they were able to do this?

M
If that's allowed I think we should flip the question around and say is there any reason to not allow a group reporting option, because I think everybody would be— I can't imagine anybody not being in favor of this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So maybe we can keep it if there is latitude within the legislation, but maybe you can double check, Josh, because it seems strange ... everybody and then everybody would get paid for one group report.

M
I mean it's basically just grouping the payment. There's still—

David Lansky – Pacific Business Group on Health – President & CEO
But it's grouping the reporting you said.

M
But there's also the issue of the demonstration of meaningful use because, of course, in many practices attributing a particular patient to a particular clinician is a challenge, which is part of what's happening in the discussion with the committee in the hearing.

David Lansky – Pacific Business Group on Health – President & CEO
So I guess I'm not clear why we're posing this as a public question, because if it is an option we should exercise that option and I don't think there's anybody that would be opposed to that. I don't understand why we're asking the public to comment on whether or not there should be an option.

M
Well, actually, if we want CMS to do it may be having the question showing support would push it.

M
I guess I don't mind.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, as long as it's really true that you could come under a group report and then everybody in that group gets the money. I just didn't think that that was possible, but if you've verified that then we could pose the question so that we can have support or illustrate what the support is for that option.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Isn't this essentially the entity level where we're talking about, in the other discussions, that they would be able to report from that EHR? I mean, Neil, do you think you're going to be reporting for each individual provider at the Institute?

Neil Calman – Institute for Family Health – President & Cofounder
We've interpreted that as what was required—

M
Same here.

Neil Calman – Institute for Family Health – President & Cofounder
If that's not what was required we could save a hell of a lot of work.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it changes almost everything.

Neil Calman – Institute for Family Health – President & Cofounder
And also the registration stuff that just came out seems to imply that every provider has to register separately for payment, so in some way you're going to need to be able to connect the registration to the data that you're providing. I mean I really have not looked at this closely, but I've been assuming from the beginning that we would have to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right. So this is off-line work—

Neil Calman – Institute for Family Health – President & Cofounder
Yes, definitely.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But I think this would change almost everything we do. This would change everything we do, so it's worth confirming.

Was there an eighth question? I think there was. I know there are some questions that we've put back up into the matrix. Is there another eighth general question that we had, we came up with?

Christine Bechtel – National Partnership for Women & Families – VP
I think we had a couple and I, frankly, don't know what was in the matrix or not, but one was we mentioned wanting to have a question on advanced directives. My concern is there is some stuff in the matrix, but I'm worried that people aren't going to understand what's in the matrix. I think rather than leaving stuff that we're hoping people comment on in the matrix, if we have an explicit question I think it's clearer and safer to include it here and so I would translate what's in the matrix under advanced directives into an actual question here.

Then I had two others that I can remember that we talked about. If you want, I can say what those are and then I have a new one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right. Keep going.

Christine Bechtel – National Partnership for Women & Families – VP
So the ones that we talked about were under patient and family engagement, whether there is an on-ramp criteria for stage two that would help providers succeed at getting to stage three because we have the blank columns under stage two.

Then we talked about; actually, I asked this question, but I'm not sure that folks wanted to ask it, which is what other ways should we foster information exchange. I was remembering the letter that we got from some of the HIEs like more than a year ago saying, "Hey, you guys missed the boat. There was real opportunity to support information exchange and you didn't do it." So I just thought it was worth a question specifically about what are the ways we can begin to really foster robust information exchange in stage two.

Then the new one that I was thinking of, I was listening to Farzad earlier. I don't if he's still on, but I think CMS and ONC and we do as well, are going to continually struggle with how to measure a lot of these in a way that isn't particularly overly burdensome for providers, but yet begins to move us away from attestation as well. I know we had some long discussions about this in the stage one context, but I'm wondering if it's worthwhile to ask a question here so that folks might suggest some innovative ways to measure particular objectives electronically, in an automated way so that we can move away from attestation in as many areas as possible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good questions.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's see. I think eight we're probably all going to agree with. We've been asked to explore advanced directives more so we can bring that out into explicit questions. They're included in the matrix, but it's much better to bring it out here. That's good.

Nine: We talked about ways of introducing the blank spaces that you referred to.

Ten: The open question of other ways, because we've been charged to find ways to push harder on HIE in stage two, so that seems also appropriate and we ... came up with what we came up with.

Eleven: Can I ask, David Lansky, whether this is a question that his workgroup also is focusing on? That's the automated measurement with—

Christine Bechtel – National Partnership for Women & Families – VP
Well, I'm on the Workgroup, Paul, and I think for the functional criteria, no. He could speak better than I can probably to automated reporting of quality measures, but a lot of the functional measures are things that are like yes/no. You're either doing it or you're not and they had to be measured in stage one on attestation. So I was really thinking more about the functional rather than the quality measures. I'm hoping that the vendor community could think through some innovative ways that they can reach in and pull out what functions and features are being used and how often so that providers don't have to do that and they don't have to fill out lengthy surveys.

M
I like the idea of including this one.

Deven McGraw – Center for Democracy & Technology – Director
Me too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I also do. Let me understand: You can certainly if, let's say, through PHRs you're gathering functional data. What is it that you'd be asking? I mean obviously you would be able to report on that. What is it that you'd be asking them to do or to measure?

Christine Bechtel – National Partnership for Women & Families – VP
Well, I'm going to pick one and I'm not a tech person and I'm not a doctor, so I may pick a bad example, but we'll keep going until I get a good example. So, like recording demographics or e-prescribing. Under stage one they obviously had to attest that X percent of their orders were transmitted at e-prescribing. How are we going to measure that in stage two? Is there a way for a vendor to go in and look at the total set and pull out a report and automate that report and submit it electronically to CMS? How do we know

that 80% of patients have demographics recorded or they've implemented drug formulary checks? Does that make sense?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. So you're asking for other ideas, just like we did about the up-to-date, so what are the ideas. David Bates had mentioned you can look at labs to see if some of the things that are diagnosed with labs, diagnostic tests, show up on the problem list. You're saying what other ideas like that can we use to automatically report on your—

Christine Bechtel – National Partnership for Women & Families – VP
Well, I think I'm not sure if I'm saying that, because I think the question is if you look at labs who is the you? Is it the doctor that has to go in and look at labs and figure out the percent and then how do they report that? Do they write it down on an attestation survey? Because that's how we did it in stage one and then you submit that. Or is there an alternative way that the vendor communities actually automate a lot of this reporting? Somebody builds—I mean I'm making this up, but—somebody builds a program that goes into the report you want and it goes into the system and it figures out, based on whatever logic, like David just articulated, but it figures it out and it submits the report automatically to CMS so the practice can't tamper with it. But it would be a really cool way to give the practice early heads up as to how well they're doing and they don't have to fill out an attestation survey. They don't have to count paper. Do you see what I'm saying?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. So is there support for asking? I mean this is a good idea. Is there support for asking that question?

M
I think it's a good idea.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Anything more?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I have one. It's probably a question for Deven, because I can't remember where we left off on this and it may be a completely bad idea, but it seems to me that we had several discussions in different contexts around the role of physicians in helping patients understand privacy practices and policies and things like that. We had talked at one point about the fact that ONC and OCR are doing this education campaign and creating materials that clinicians, as the trusted messengers, could use with patients.

I just wondered if we wanted to ask a question, because I think there was a lot of pushback when we raised this because people said it's too burdensome. But the question in my mind anyway is if clinicians had a standard set of materials that were provided to them by OCR or through the RECs, is it really too burdensome or is there value in having clinicians play a role in this area.

Deven McGraw – Center for Democracy & Technology – Director
I don't necessarily object to the question, but really, number one, we have no idea what those materials look like.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I know.

Deven McGraw – Center for Democracy & Technology – Director

Or what they could look like and whether we're even going to think they're terribly effective from a consumer side or whether the physicians will think they're terribly effective. We certainly in transparency discussions in the Policy Committee have noted that while the information might best be received from a patient's clinician where there is a chance to ask questions it's also, number one, they're not necessarily the most knowledgeable; nor do they have the time to spend that kind of detail.

I happen to like the way we've, in an overarching way, handled the privacy and security category overall, which is to say that there are other workgroups sort of teeing this up and there's an interplay between meaningful use and the grant programs and NHIN conditions of trust and interoperability. I don't think we go into this much detail, but there are other things in motion here, which are going to yield some criteria that may be added later. I'd much rather stew on this one a little bit, but I definitely appreciate the thought.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think that approach makes sense, so I don't think we need to add that question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you. Anything more? Okay. I think we're ready for public comment then, Judy.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you please check and see if anyone wishes to make a comment?

Operator
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul, while we're waiting, what's your sense on February 3rd?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good point. Okay. So we have two calls scheduled. One is February 3rd and the other I believe is February 12th or something or February 15th—

Judy Sparrow – Office of the National Coordinator – Executive Director
The 15th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think we don't need a February 3rd call. Any objection to that?

W
Sounds good, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The question is does it get better? Do we even need a February 15h call since I think our next step in the process is to get back the information from the public comment. We have the 30 days and then we have approximately a 4-week time when ONC; it depends on how many comments come in; but come and summarize it. Then we would need to meet and digest that summary and talk about updates in preparation for presenting an updated set of draft recommendations to the full committee. We're thinking that that ends up being, with these 30-day intervals, in the April time frame and then working our way

towards to say we're trying to get into making it by June or July, like we did the last time around, getting that final recommendation out to ONC ....

So I don't know that we're going to have new business for February 15th, in that time frame.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right.

M
We won't have any sort of analysis yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

M
I mean the public comment period will basically be coming to a close right about that date, so—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So this could be especially ... can we give the group two days, two times off?

Judy Sparrow – Office of the National Coordinator – Executive Director
Sure.

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right.

Judy Sparrow – Office of the National Coordinator – Executive Director
Done.

W
We can.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. Thank you. This was a very productive call and I think we've enriched and improved the criteria that we've set out for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right.

Neil Calman – Institute for Family Health – President & Cofounder
One comment: Are we going to get some information through the Meaningful Use Workgroup? I don't know whether we're just on the production end or also on the receipt end of some stuff, but are we going to get information now that the registration process is open at what's happening from that process?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. I think not only we are, but the full committee will. But, Josh, maybe you want to elaborate on that?

Josh Seidman – ONC
Neil, I can report that the first Medicaid payments or AIU have been made.

Neil Calman – Institute for Family Health – President & Cofounder

What?

Josh Seidman – ONC
$2.8 million to a hospital in Kentucky yesterday and two physicians in Durant, Oklahoma yesterday. So these are obviously dependent on the state. Every Medicaid program is in a different place and so some are ready. If you're interested, Neil, I can send you the list of where states are. So some states are already doing that. Obviously, that's just for AIU. We can get you more information as it comes along.

Neil Calman – Institute for Family Health – President & Cofounder
Has your service been brought to their knees because of all of the registrations?

Josh Seidman – ONC
You'd have to ask FEMA.

Neil Calman – Institute for Family Health – President & Cofounder
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
Josh, I'd love to see the list.

Josh Seidman – ONC
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great. Any public comments, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
Is there anything in the queue?

Operator
Yes, we do have public comment. We have Ms. Douglas in queue.

Genevieve Douglas – VNA – Reporter
Hello. This is Genevieve Douglas. I'm a Reporter with VNA and I was just wondering when this document could be anticipated to appear in the Federal Register.

Judy Sparrow – Office of the National Coordinator – Executive Director
We don't really know. We haven't finalized it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Just in the fairly near future.

Operator
We do have another comment. Ms. Chantal, you're in queue.

Chantal Worzala – American Hospital Association
Hello. It's Chantal Worzala at the American Hospital Association. Thank you so much for having this call. Following on to the previous question, I would like to suggest that the comment period for this particular solicitation be 60 days. This is a very important set of recommendations. We are in a period right now where there is a tremendous amount of activity going on. There is an open call from ONC in the RFI, the PCAST Report. We've got folks trying to figure out exactly how they do their registration. Many, many folks still wading through the almost 150 FAQs on the current stage one meaningful use requirements and we really need some time for folks to be able to know that this is out there, give it some considered

thought and give you really solid feedback. So I would request that this have a 60-day comment period. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you very much. Any other comments?

Operator
We do have another comment from Reg Smith.

Reg Smith – Mayo Clinic
Yes, this is Reg Smith from Mayo Clinic. There are two comments I'd like to offer. The first one is in the meaningful use measures for stages two and three you've added the comment for fits patient's preference. I wanted to point out to the group that for people who have large referral practices—that is for much of Mayo Clinic—more than half or at least half of our patients come from outside of the immediate service area. So this provision is very, very important to us from the standpoint that we could never meet meaningful use if we had to do 60% or 80% of all orders without this provision for patient preference. Because a number of patients really prefer to take written prescriptions back to their home area, which may be a journey of some distance away from our primary service area before they actually get the prescription filled. So I think that's a very important provision and wanted to speak in support of that. We very much appreciate that accommodation.

The other area is in the discussion of how personal health records fit into this whole scheme, because I don't think as I've looked at the various personal health records. I haven't been out there most recently, but patients have very little rights with regards to how their information is protected if you go to HealthVault or the Google Health Record and so on. I think it's very important that they be held to the same standards in terms of privacy, confidentiality and protection of the patient data, that they have some obligation to the patient to keep it confidential and secure. That we not waive the requirements we expect of the HR vendors on personal health records simply because they're in the private sector or the business sector. I think they need to be held to the same standards.

Those are my two comments. I do enjoy these discussions very much. Thank you for allowing me to speak my mind.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Dr. Smith. Good comments. Anybody else?

Operator
We do not have any more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Dr. Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'll just make one comment in response to Chantal, because we really appreciate that sentiment. Sometimes it's a little bit of be careful what you wish for because, as you know, the industry is both, on the provider side and the vendor side, ... advanced notice as possible, so we're actually trying to respect that request to get the information out ... as early as possible. That's actually part of what's driving the 30 days. As I said before, last year it was like ten days, but we definitely hear you and respect that. We're trying to also respect the request that we move it up as quickly as possible.

Anyway, so thank you very much to the Workgroup and thank you for participating in your hearty discussion. See you next time.

Judy Sparrow – Office of the National Coordinator – Executive Director

All right. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Happy New Year!

Public Comment Received During the Meeting

1. My comment is that if ONC and CMS are to look to vendors to provide automated e-submission of the automated calculated measures, two things need to be considered (and maybe are things to ask the public). 1. We really need specification development for the automated calculated measures that eliminate a lot of the ambiguity we think present in the regulatory language for the measures. We suggest taking great care not to create contrivance for clinical workflow to be able to document the input data necessary for the measures that creates burden on the provider that does not fit well with care delivery.

2. The AMA has heard that ONC is considering a comment period of 30 days for the stage 2 RFI. We are very concerned this will not allow for adequate time for the public to respond. We strongly urge ONC to institute a 60 or at the very least 45 day comment period. Thank you.